Darlington

Integration and Better Care Fund

2017/19

Area	Darlington
Constituent Health and Wellbeing Boards	Darlington
Constituent CCGs	Darlington

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1. Introduction / Foreword

The Better Care Fund Plan 2017/18 – 18/19 seeks to build on foundations laid in 2015/16 and 2016/17 in the areas of admissions avoidance in 65+, a joint approach to discharge management, reablement and intermediate care services, improving health in care homes, and building a robust community and universal services offer in support of managing demand into the future.

Funding sources	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Darlington CCG	£7,404,433	£7,545,117
DFG	£804,133	£868,491
iBCF	£2,352,800	£3,156,213
	£10,561,367	**£11,569,821**

Schemes detail can be found on pages 30-34

Agreed Outcomes linked to schemes

- To have more accessible and effective integrated care to support older people and their carers to stay healthy with long term conditions through early invention and prevention avoiding unnecessary complications and acute crisis.
- To improve the experience of older people who are admitted into hospital and to ensure they do not remain in an acute hospital bed for longer than is clinically necessary
- To ensure early diagnosis, treatment and ongoing support for people with dementia and their carers through good access to services and information promoting independence for as long as possible
- To improve the health, wellbeing and safety of people living in care homes
- Enabling people to tell their story only once through agreed joint assessment and care planning processes.
- Improved partnership and collaborative working
- Reduce duplication of services with people seeing the right person, right place right time.

BCF priorities 17/19

The plan has seven broad workstreams:

- New models of Care and personalisation of services including through technology and domiciliary care
- Healthcare services to Care Homes
- Equipping people to be resilient and self-reliant through Primary Prevention/Early intervention, and Care Navigation
- Intermediate Care and improvements to reablement and rehabilitation services

- Further improving Transfers of Care through the implementation of the High Impact Change Model
- Supporting carers and delivering DFG adaptations
- Improving Dementia Diagnosis and post diagnosis support
- This plan is developed in partnership between Darlington Borough Council and Darlington CCG.

The plan has been signed off by the Health and Wellbeing Board which also includes providers, housing, voluntary and community sector representatives, and other partners across the health and care economy, in accordance with its terms of reference. Health & Wellbeing Board Governance

A pooled Budget Partnership Board provides the forum for agreeing expenditure and evaluating schemes, and an intermediate care delivery group and local discharge delivery board (commissioners and providers) oversee planning and delivery. Terms of References are at Annex 1.

As a Unitary Authority Darlington is the responsible housing authority in receipt of the DFG.

2. The Local Vision and Approach for Health and Social Care Integration

Darlington has a shared, agreed vision for a sustainable health and social care economy articulated in the Health and Wellbeing Plan, and derived from the sustainable community strategy *One Darlington: Perfectly Placed*, which serves as Darlington's Health and Wellbeing Strategy.

This Better Care Fund plan is a key delivery mechanism of the Health and Wellbeing Plan, developed jointly by Darlington CCG and Darlington BC, "owned" and signed off by the Health and Wellbeing Board. The Health and Wellbeing Plan is under review and will be signed off by Health and Wellbeing Board in Q3 2017/18. The plan for Darlington places the community at the heart of commissioning intentions to improve health and wellbeing and to reduce health inequalities for the population.

There is a clear ambition for Darlington, as set out in *One Darlington: Perfectly Placed*, the shared strategy across public, private, voluntary and community sector partners. It is about a new deal for Darlington in which everyone has a part to play in creating a future in which people do not miss out on the opportunities arising from living and working in Darlington on account of a lack of income, where they live, or by any other potential disadvantage, including people with protected characteristics under the Equality Act 2010. That is what is meant by "One Darlington". In parallel, the strategy aims to make Darlington "Perfectly Placed" by creating sustainable growth.

Local Vision – "A sustainable health and social care economy in Darlington that places citizens at the centre of the model and which builds strategies and services around them. Personal responsibility, prevention of harm, self-management of conditions, prompt access to primary care and easy access to general acute services will form a continuum of provision in Darlington, with some more specialist services being provided elsewhere"

Delivery of this vision will focus on the principle of delivering the best outcome for Darlington people, rather than what is the best outcome for the services, many of which have responsibilities beyond Darlington.

3. The Vision in context: The wider health and social care landscape

Work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View, the Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation.

That transformation is driven by the sharp and continued fall in resourcing, and the search for a response which preserves services. In adult social care, that transformation is significant, and will see the service change much over the next two or three years. More widely, however, the impact of reduced investment in those aspects which make Darlington a "Place designed to thrive" and which make a significant contribution to health – social and community networks, and general socio-economic, cultural and environmental conditions such as jobs, education, housing – is an additional challenge.

Intermediate care happens in between health services and home. It is the lynch-pin in the health and social care system so it is imperative that it delivers effectively the services that will help keep Darlington residents independent, healthy and safe in their own community. The transformation of intermediate care services begun at the end of 2016 will result in improvements to those services designed to keep people safe at home or to speed their return home if a hospital stay has been unavoidable.

The transformation agenda for public health is based on a shift in focus from tackling ill health and treatment to tackling the causes of health inequalities, particularly the wider determinants of health and focussing 'upstream' on prevention in the population.

The Health and Wellbeing Strategy, One Darlington: Perfectly Placed supports a population approach by providing a framework for a focus on People and Place. This provides a framework for the Health and Wellbeing Plan for Darlington – and this BCF Plan - to set out the approach of focussing on 'upstream' activity to address the wider determinants of health, including social, cultural, economic and environmental conditions, which the evidence indicates are the underlying causes of poor health and inequality.

The CCG two year operational plan articulates how it is intended to achieve transformation at scale and pace in order to deliver the requirements of the 'Five Year Forward View'. Building on the progress already made during 2016/17 and focusing on the following areas:

- Further strengthening of partnership working with all providers and other CCGs across our Sustainability and Transformation Plan (STP) footprint in order to understand the shared opportunities and wider impact of respective plans
- Continue to build on strong history of working in partnership to drive improvements in the health and wellbeing of the local population
- Detailing the quarter on quarter benefits of the transformation programmes planned to deliver the expected outcomes

In June 2016 a vision of "meeting our communities needs now and for future generations, with consistently better health and social care delivered in the best place" was set at STP level. This was supported by a clear articulation of the challenges associated with an overreliance on hospital based services. To do nothing was not an option. The plan is ambitious, and will deliver a transformed system for the local workforce and local population.

The plan intends to see everyone get healthier, but also to ensure that the health of the most vulnerable is as good as that of the most fortunate. The plans are focused on reducing unnecessary demand and reducing waste and inefficiency, whilst maintaining high quality services. These are the challenges we must face up to. “We” being the GP practices, the patients, the community, the providers of services and other partner organisations we work with including Local Authorities. “Good health is everyone’s business”. This will lead to better patient outcomes with shorter hospital stays, improved access to GPs and a financially sustainable system, the Better Care Fund is one of the ways in which we can drive forward the partnership approach to dealing with these pressures and retaining the health and wellbeing of our local residents at the heart of what we do.

Sustainability and Transformation

The Darlington, Durham Dales, Easington and Sedgefield, Hambleton, Richmondshire and Whitby, Hartlepool and Stockton-on-Tees and South Tees Sustainable Transformation Partnership’s plan “Working together to improve health and care” identifies four areas for improvement and this Better Care Plan will take account of these and apply them for the people of Darlington:

- Preventing ill health and promoting self-care. This involves helping to stop people from becoming poorly and helping to manage their health and any medical problems they already have.
- Health and care in communities and neighbourhoods. Supporting people to stay well and independent for as long as possible by improving health and care services within their area. Known as “New Models of Care” in Darlington, this approach will bring primary and intermediate care services together, into the community. This will help people get the services they need, in the area where they live, and help minimise unnecessary hospital visits.
- Quality of care in our hospitals – “Better Health Programme”. This is about improving the quality of care in hospital and reducing the distance people have to travel for routine appointments e.g. blood tests, but making sure that people get the best treatment and see the right specialist when they need to.
- The Better Health Programme will review the services provided across Durham and Tees Valley – which includes Darlington - to make sure that these are meeting the needs of the population, are of a consistently high standard, and have the staffing and resources to be sustainable into the future.

Delivery models in 2017 - 2022:

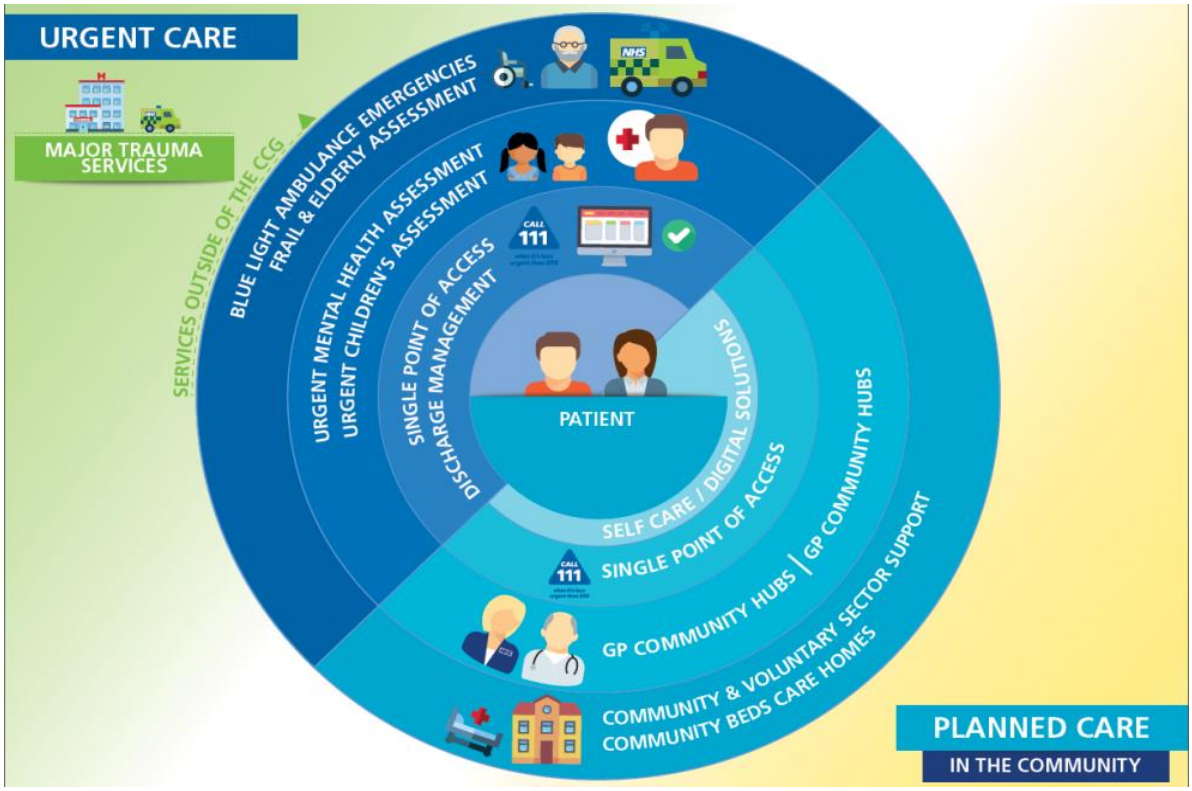
- The changes to primary and community based health care in Darlington emerging from the Better Health Programme “New Models of Care” (Diagram 1). BCF is a key enabler in the “planned care” area of this model.
- Transforming adult social care using iBCF, ensuring that adult social care services are well placed to meet the changing needs of the population
- Ensuring that the joint commissioning of services, initiated by the Better Care Fund, becomes the model for person-centred multi-disciplinary planning and delivery – particularly in the area of d Intermediate Care.

New Models of Care

The system change required is the creation of functionally integrated holistic teams at a community hub level. These teams should include community services, allied health professionals, social services, specialist nurses, the Voluntary and Community Sector and be linked to GP practices. The integrated health and social care teams will be based around a Community Hub population of 30-50,000 to provide joined up, accountable and personalised services. Integrated teams will pool expertise to deliver a bespoke service at the benefit of individual patients.

Diagram 1 demonstrates how primary care will become integrated into the identified model and services will transition to community hub settings, through physical or virtual delivery models with the overall focus of the Multi-Specialty Community Provider (MCP) model being early intervention and prevention with one focussed Single Point of Access supporting a number of hubs across the locality.

Diagram 1. New Model of Care



Local Model of Care

The STP outlines the following local developments across Darlington in order to drive forward partnership working across health and social care services and is reflected in the vision of the STP and that of the BCF plan. Locally the following will be developed to support the delivery model:

Community hubs - GP practices will be brought together into groups of practices called 'community hubs' so they can share their skills to match the needs of our residents.

Community hubs allow patients to benefit from the knowledge and expertise of local GPs within their hub, and reduce the need for unnecessary attendance at hospital.

Care Co-ordination - The public have outlined that accessing services is confusing when unwell. The single point of access for the public, will allow people to attend and be seen by the most appropriate health services. The centre will have an overview of all health services and teams, including professional teams working in hospitals and the community. This will ensure patients are seen appropriately whether that is being assessed in hospital or staying at home with effective community support.

Discharge Management - Patients can often stay in hospital longer than is necessary. Health and social care services are working closely to improve support for patients leaving hospital, so they can be discharged quickly when it is medically safe to do so.

Care Planning – There is the intention to develop care plans that can be completed with patients (or their carers) with long term or complex health needs. Care plans will ensure their views, priorities and preferences are recorded. This will include how the patient wishes to be cared for should their circumstances change. The care plan will be shared with, and visible to, health and social care staff who are caring for patients. This will reduce the need to repeat conversations and record details with several professionals.

Community and Voluntary support - Will build and encourage the development of the voluntary sector so they can support patients care in the community, ensuring health and social care services are used well.

The BCF plan builds on services commissioned and developed over a number of years and has interdependencies with wider plans across health and social care, including links with the New Models of Care, Darlington Joint Health and Wellbeing Strategy and Local A&E Delivery Plans.

Joint Strategic Needs Assessment

Health and Wellbeing Strategy: *One Darlington Perfectly Placed*

Sustainable Transformation Plan

Darlington CCG Care Blueprint

BCF Plans will continue to support previous BCF National Conditions within its plan for 17/19 including:

Delivery of 7-day services: Darlington GP Practices are part of an early adoption of integrating with 111 services for out of hours and emergency calls, ensuring a 7-day service for primary care.

Weekend discharge has been in place since October 2015 and is generating positive feedback, but Darlington remains in the lowest quintile for this metric on the NHS-social care

interface dashboard, indicating we have more to do. The work to implement all of the high impact changes will address this:

In adult social care the iBCF grant will be used to expedite extension of appropriate seven-day support to discharging patients.

The Responsive, Integrated, Assessment Care Team (RIACT) service in Darlington operates a 7 day service preventing admissions and enabling planned hospital discharges, and the improvement plan being implemented with the help of iBCF grant will embed this approach. This is a joint service between social care and CDDFT Community Health Services (Therapists, Stroke, Falls, Nursing, Social Care, In-house Reablement service and independent providers). This is an integrated system, co-located with a single point of access offering support to GPs, out of hours GPs and hospital services covering core hours, 8 till 8 seven days a week.

ICT Systems and Data sharing

It has long been recognised that sharing information between care providers to inform the best decisions at the point of care and for the patient to only have to their story once, would improve patient care and outcomes, whilst also improving patient experience. Through a phased approach to achieving an integrated digital care record the achievements to date have been:

- Sharing GP records with Out of Hours Primary care services, by integrating the Medical Interoperability Gateway (MIG) into the providers clinical system.
- Sharing of GP information with the 15 regional Acute, Mental Health, Out of Hours and Ambulance Providers. Initially just for urgent and emergency care, then rolled out Trust wide.

All Practices in Darlington have signed up to sharing their information through Information Sharing Gateway (ISG). The ISG is a regional online portal that hosts the data sharing agreements between each of the organisations where the data flows.

It was quickly recognised that developing a system for sharing a fully integrated digital care at a locality level, was potentially unaffordable and patients access services across the region, meaning that it needed to be developed at a larger scale. The Great North Care Record is a project led by Connecting Health Cities, partnering with GP practices, hospitals, community, ambulance, mental health trusts and Local Authorities with the purpose to make an agreed set of information from each organisation immediately available between health and care professionals using a secure, electronic system to help provide the best treatment.

The Great North Care Record, will develop and procure a system through using Application Programming Interfaces (API's)and will also develop a consent model that lets the citizen choose their preferences for who can view their data and also the purpose the data can be used for (Direct Care, Commissioning of services and potentially research).

A joint approach to assessments and care planning:

The Local Discharge Delivery group will oversee further development of existing joint working around assessments and care planning in the interests of improving patient flow and maintaining Darlington's good performance in respect of Delayed Transfers of Care.

Agreed Outcomes linked to schemes

- To have more accessible and effective integrated care to support older people and their carers to stay healthy with long term conditions through early invention and prevention avoiding unnecessary complications and acute crisis
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4. Background and Context

Key Issues and Challenges

The health and social care economy in Darlington faces a range of significant challenges:

Demographic changes mean that there is a high likelihood of an increase in demand on both health and social care in future years. The Better Care Fund can support a reduction in this demand by putting in place a number of strategies around early intervention and prevention and supporting people to stay independent in their own homes where appropriate, for as long as possible. It is essential that those with the greatest need are fully supported and have a co-ordinated response to reduce duplication and ensure the most appropriate services are delivered. Carers are also critical in ensuring people achieve the best outcomes and require support to enable them to maintain their caring role.

According to ONS, population growth has stopped in Darlington mainly due to a change in direction of net migration flows, since 2011 they have been outwards. Many parts of England have experienced rapid growth in recent years due to large net inward flows of international migrants but this has not been the case in Darlington.

The projected growth rate in Darlington is much slower than in the other Tees Valley local authority areas, apart from Redcar and Cleveland.

Darlington is ranked 97 of 326 areas in the Index of Multiple deprivation, placing it in the top 30% least deprived areas.

An Ageing Population

People are living longer and, whilst the increase in life expectancy is welcomed, this presents challenges for health and social care services as people living longer often have complex health conditions and require significant levels of support to remain independent.

Research shows that older age is associated with an increased incidence of multiple long term conditions and a growing number of functional and cognitive impairments. It is estimated that 58% of those aged 60 and over report having a Long Term Condition (LTC) with 25% of over 60s having two or more LTCs. For Darlington this would mean that by 2020 there will be approximately 5,500 over 65s with two or more LTCs.

As set out earlier, the 65+ population is undergoing considerable growth. We expect an increase in the population aged 70-74 of around 20% (just under 5000 to almost 6000) by 2021 on 2016 figures. This will be followed by an increase of 30% - 40% in the 75 - 80 cohort, which will grow from just over 4000 to almost 5500 between 2020 and 2025. These forecasts will influence the design of services.

By 2034, over 1 in 4 of the population is projected to be aged 65+. The considerable increase seen in the number of over 65s is projected to continue by an average of 400 per annum, reaching 28,700 in 2034 (increase of 43%). The number of over 85s is projected to more than double by 2034 to reach 5,600, with an average increase of 800 per annum.

The numbers of 65-74 year olds is projected to increase. These will become more economically active as State Pension Age (SPA) rises [women's SPA is increasing gradually to be same as for men in 2018, then both to 66 in 2020, and 67 in 2026].

The higher SPA is projected to increase labour supply by 4,900 in 2034. SPA changes maintain the number of working age residents at between 62, 4000 and 65,000 over the 20 year period.

Life expectancy, for people born in Darlington, increased steadily since 2000 for both men and women. However, the latest information available indicates that since 2011, for men, and 2012, for women, life expectancy for people born in Darlington has decreased, widening the gap between England and Darlington.

The prevalence of registered patients diagnosed with dementia in Darlington is higher at 1% of the population in Darlington compared to both the North East region (0.9%) and England (o.8%). There has been a steady upward trend in Darlington from 0.7% in 2011/12 to 1.0% in 2015/16. This has been similar to the trend regional and nationally. Many dementias are vascular in nature with similar interventions as described for CHD for reducing the risk of developing the disease in later life. Stopping smoking is the most effective preventative action that can be taken by an individual to reduce their risk of dementia in later life.

These trends have resulted in a growing demand for health services to treat multiple long term conditions as well as care services to help individuals cope with everyday activities such as dressing, bathing, shopping or preparing food.

Given the ageing population and associated levels of need for health services, this is expected to increase significantly over the next 5-10 years if services continue to support people in the current way. The demand on social care services and particularly long term care is also predicted to increase significantly over this time period.

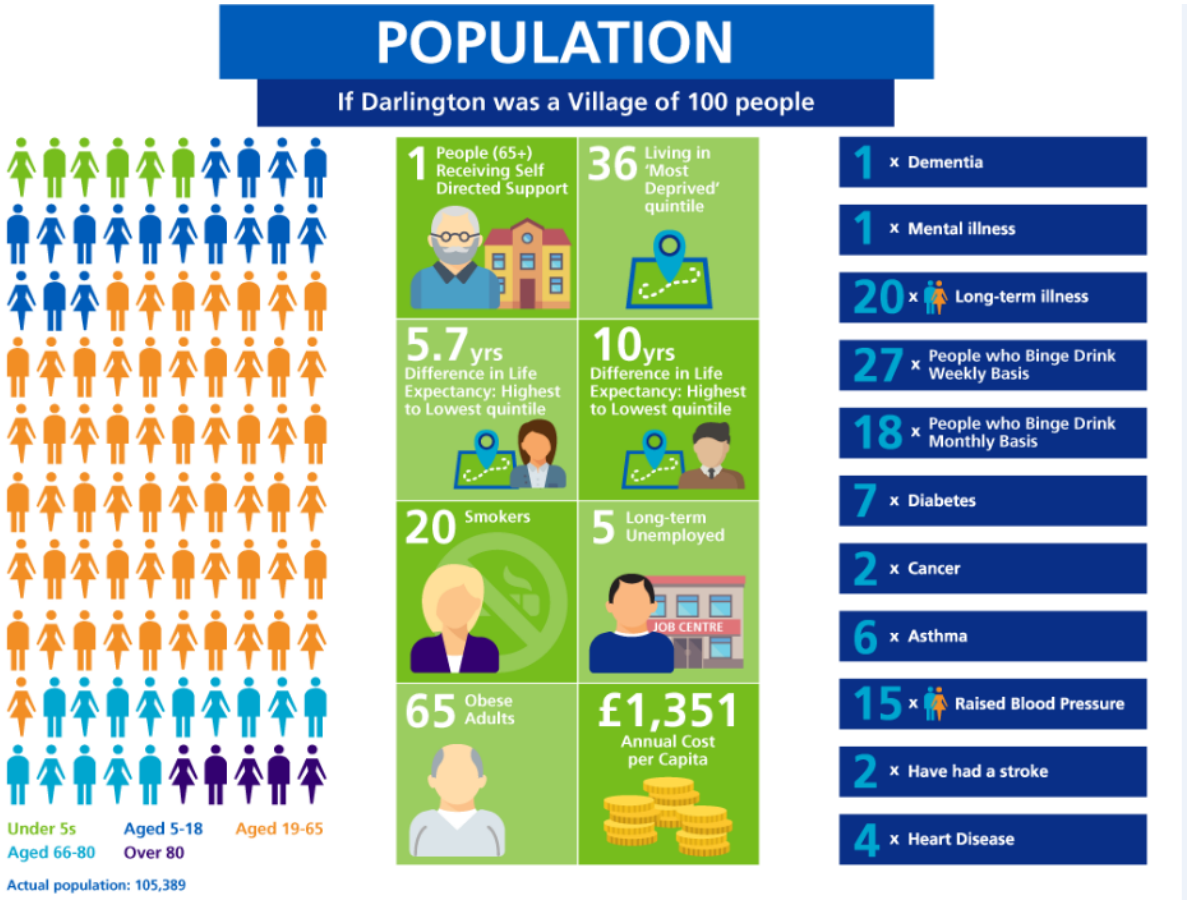
It is anticipated that further integration of health and social care services will help to address these issues through:

- Risk stratification and targeting of resources at those people who are most at risk of poor health outcomes and most likely to require intensive health and social care services in the future.
- Improved care planning, care co-ordination and care delivery.
- Better use of limited resources through multidisciplinary assessment and responses.
- A shift from reactive services to a more planned approach focusing on early intervention and prevention.

Fuel poverty in Darlington remains worse than the regional and national average. The disproportionate effects of cold housing on older people, combined with the projected increases in the older population indicate that there will likely be a greater number of older people living with fuel poverty and suffering the effects of cold housing with the oldest people in our communities being most vulnerable to living in fuel poverty. and the effects of living in cold housing. The significant increase in the number of people over the age of 85 years who will be living in fuel poverty is likely to increase the demand on health, care and support services particularly those high cost , high intensity services such residential care.

ONS Population Projections analysis

The diagram below demonstrates if Darlington was a village of a 100 people the prevalence of long term conditions and demand for health and social care would be predicted to be;



Wider Determinants of Health

As the Marmot Review made clear, a person's health and wellbeing in later life is affected by a wide range of determinants such as poverty, housing, employment and education, as well as healthy lifestyles and health care. The Darlington Better Care Fund recognises these wider determinants of health and promotes earlier intervention through a more holistic approach to care planning, which incorporates low level services, early intervention and prevention, housing issues, social isolation and healthy lifestyle issues.

Workforce challenges

Locally the review of current systems and processes helps to take advantage of new opportunities and approaches to healthcare; however the future challenges cannot be met by one organisation and the importance of working with our stakeholders and partners to deliver effective change is priority, whilst ensuring we continuously seek patient's views and opinions from users of services. Collaborative working is underway with Providers, other CCGs across the STP footprint and our Local Authority Partners to better understand the

implications of proposed STP intentions on workforce with a particular focus on primary and community care implications and requirements.

From a health perspective many challenges relate to the availability of clinical specialist skills and workforce to consistently ensure senior decision making clinicians are available for an extended day, seven days a week, supported by sufficient numbers of junior doctors, nurses, health scientists, etc.

A high proportion of GPs are over the age of 50 which creates a risk in terms of expected retirements; the challenge is in ensuring that there are enough newly qualified GPs to replace this cohort.

Nursing and midwifery will be effected by recruitment difficulties and high vacancy rates across the nursing profession and specialist nursing roles; Factors include the impact of graduate-entry nursing on the skill mix, attrition and the number undertaking undergraduate courses..

Actions being taken include:

- Investment in the primary care workforce: this includes increasing the number of staff working in primary care in substantive posts and training schemes, by a range of recruitment, retention and education initiatives aimed at the entire primary care workforce encompassing practice nurses, pharmacists, health care assistants, practice management staff
- Investment in the band 1-4 workforce to reflect an increasingly patient facing role. This includes enhancing competencies to ensure that they can deliver their current roles and also, where appropriate, additional roles traditionally undertaken by other staff.
- Introducing new roles, changing skill mix and expanding roles of staff; for example advanced practitioners and healthcare scientists undertaking roles previously assigned to medics and physician's associates, working across secondary and primary care in a variety of services.
- Ensuring that the continuing workforce development of staff is reflected in the investment by employers but also by HEE NE.
- Continued work with care homes, hospices and the voluntary sector to understand their education and workforce issues.
- Working collectively and individually to reduce turnover and increase retention of the workforce and seek to deliver a more efficient and effective use of bank and agency staff.

From a social care perspective, recruitment and retention of key professionals (Social Workers and Occupational Therapists) has not been a particular challenge locally. However, it is recognised that there is an ageing workforce in some areas and succession planning is essential in order to ensure that sufficiently qualified and experienced staff are available in the future to meet local need. Turnover of qualified staff (particularly within social work) has been a challenge in recent years as experienced social workers have moved on and been replaced by newly qualified social workers undertaking their Assessed and Supported Year in Employment (ASYE). This approach is very positive for the newly qualified professional but the protected caseload and the commitment required from assessors and mentors creates pressures within the wider workforce in the short term.

The most significant pressure within adult social care relates to commissioned services and specifically the recruitment and retention of qualified nursing staff within care home settings. This issue has impacted on quality of care in some local homes in recent years and has ultimately affected ongoing viability of some services. A number of care homes have ceased to operate locally in recent years, or ceased to provide nursing care, citing recruitment and retention of nurses as one of the factors influencing this outcome.

Recruitment and retention of care staff is also a challenge for some providers in relation to turnover and the provision of development opportunities / career pathways within the care sector. Current work with local Further Education providers to explore the development of a Care Academy aims to tackle some of these issues.

Market Challenges

The Care Act 2014 strengthened the role of Local Authorities in market management and requires local authorities to help develop a market that delivers a wide range of sustainable high-quality care and support services for their communities.

Local authorities are also required to engage with local providers, to help each other understand what services are likely to be needed in the future, and what new types of support should be developed.

Darlington's Market Position Statement (MPS – currently under review) sets out how, through market facilitation and commissioning activity, the vision for Darlington outlined in the Sustainable Community Strategy "One Darlington: Perfectly Placed" can be realised, not only through the delivery of care and support services, but also in the way in which health and social care partners actively contribute towards economic growth and employment opportunities for the people of Darlington.

The MPS sets out the ongoing direction of travel which will continue to shape delivery of adult and children's care and support services. As such, it has been informed by and builds on Darlington's Health and Wellbeing Strategy, which provides strategic direction for decision makers in local health and social care services based on challenges identified in the Joint Strategic Needs Assessment (JSNA). It also underpins a number of local Strategies including:

- Looked After Children Strategy and Sufficiency Statement
- Special Educational Needs and Disability Strategy
- Early Help Strategy
- Adult Commissioning Strategy

Like many other Councils, Darlington is in a period of significant change in terms of the way public services are delivered. It acknowledges that its citizens expectations have changed, different models of service delivery have or must be developed, there have been significant technological advances, and Councils are experiencing unprecedented financial pressures as a result of the national austerity measures. These factors have and will continue to result in a change to the market landscape.

In this context, the Market Position Statement is seen as an increasingly vital part of the relationship with the care and support sector. It aims to: build on the local strategic approach and long-term vision for the future of public services in Darlington; explain what

new approaches and services are needed, and encourage partners to help shape a sustainable model of care which achieves better health and wellbeing outcomes for people from Darlington.

Nationally the funding of CHC is a significant cost pressure on CCGs spending:

- There has been a 16% increase in spending on CHC between 2013-14 and 2015-16
- 4% of CCGs total spend is accounted for by CHC
- £5,247m expected spend on CHC, NHS funded nursing care and assessment costs by 2020-21 if no action is taken (£3,60m in 2015-16)

Performance

Darlington generally performs well, and is ranked 30 of 150 local authority areas on the NHS-social care interface dashboard. In respect of four of the six metrics Darlington is in or around the top 20%. However, there are performance challenges flagged by this composite metric:

Table 1 NHS Social Care Interface Dashboard, local authorities in England for BCF performance metrics

Metric	Rank
Emergency Admissions (65+) per 100,000 65+ population	36
Length of stay for Emergency Admissions (65+)	13
Total Delayed Days per day per 100,000 18+ population	15
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	130
Proportion of older people (65 and over) who are discharged from hospital who receive reablement/ rehabilitation services	18
Proportion of discharges (following emergency admissions) which occur at the weekend	137

Resource challenges

The sharp and continued fall in resourcing in public services will be met by transformational approaches to preserving services. Each year the CCGs are faced with a significant challenge in achieving financial balance. Our committed expenditure is often greater than our expected income and therefore to achieve balance we are faced with a financial efficiency target. In 2017/18 the CCG has an efficiency target of £6 million; this target is broken down across a number of schemes across a range of areas (Elective, Non Elective, Medicines, CHC). The BCF Plan and associated work will help to impact on a number of these schemes.

The CCGs updated forecast position shows the organisation to be on track to achieve its key financial targets and Business Rules as set by NHS England. However, if expenditure continues at the current rate (i.e. “Do Nothing”) the CCG is facing a significant financial risk.

In adult social care, that transformation is significant, and will see the service change much over the next two or three years, supported by iBCF, as savings of £2.7m are sought.

DBC has maintained relatively high levels of spend per head of population on ASC compared to similar Local Authorities. This level of expenditure is not sustainable in the long term and a transformational shift has to take place in order to manage demand, maximise independence, deliver personalised outcomes and promote a cost effective and stable market.

Demand for health care services increases every year. In Darlington, there were 4817 emergency admissions to hospital for people aged over 65 in 2016/17. In addition the range of services offered has changed significantly in recent years with some services that were traditionally provided by hospitals now being delivered in the community. There is an increasing need for an integrated approach to the management of patients, particularly those with long term and complex conditions.

BCF Plans are ideally placed to proactively influence pathways across health and social care boundaries in order to ensure equitable access for people and reduce variation in approaches to delivering care.

5. Progress to date

The Local Authority and health partners have been working together on maintaining good patient flows for some time, and there are established and robust relationships in place.

Within the local authority plans are being implemented to embed strength-based assessment and to support people to find appropriate services in the community, before a crisis results in unplanned interventions.

Within the CCG work to develop and implement the New Model of Care (see figure 1) have been in train for some time with support from the LA.

Our BCF 2016/17 plan set out to deliver the following priorities:

- To reduce emergency admissions, particularly for 65+ population
- To divert and provide alternative pathways for people with needs below treatment or care eligibility thresholds
- To improve patient flows and maintain a low level of Delays to Transfer of Care
- To support people to stay independent at home and reduce or maintain numbers of people whose needs are met through permanent residential care
- To understand and plan to improve the reablement and intermediate care provision

These build on 15/16 plans to ensure delivery of the following schemes:

- Primary Prevention and Care Navigation
- Intermediate Care and the High Impact Change Model
- Domiciliary Care, Healthcare Services in Care homes and personalised healthcare at home
- Care Navigation (Long Term Conditions)

The 2017/17 plan identified key priorities in relation to:

Reducing emergency admissions

Darlington has seen a reduction in emergency admissions of adults and elderly with no long term conditions, adults and elderly with advanced organic brain disorder, elderly with 4+ LTCs, and elderly with 1-3 LTCs. However, the overall NEA has not fallen due to increases in admissions among, for example, under 16s (+12.0% activity from May-15 to Oct-15 compared to May-16 to Oct-16), and Adults and Elderly with learning disability (also +12.4% when comparing the same period).

Unplanned admissions from care homes were also slightly down in 16/17, maintaining low levels set in 15/16, reflecting the impact of bringing community matrons into care homes, and aligning health services to care homes.

In addition, the 2.6% drop in unplanned hospital admissions for 65+ is a success and interpreted as a product of the whole basket of measures being implemented.

Primary Prevention and care navigation

The Support to Wellbeing service is being trialled in 2017. Wellbeing navigators from the voluntary sector receive referrals from primary care and social care, of people with low level

and non-medical need. The service provides supported access to universal services in order to help people find services in the community that best meet their needs, building resilience and delaying need for paid for social care or primary/secondary health services. Data from the test-bed will inform the design of, and decision to proceed with, a full service commission for 2018/19 and beyond. This scheme includes the development of a single Darlington directory of universal services, available to everyone.

Aligned to the Support to Wellbeing service is a dedicated extensivist GP service for people who have significantly more GP appointments, visits to A&E or Urgent Care than average. This service aims to support these high-impact users to find more helpful services to meet their need and is expected to become part of Support to Wellbeing (social prescribing) in 2018 and beyond.

Intermediate Care and the High Impact Change Model

These schemes built on a number of initiatives introduced in BCF 2015 to reduce delays to discharge from hospital for medically stable people back to a community setting: wherever possible, this is their usual place of residence. It also contributes to delivering the "Supporting Safe Discharge" CQUIN.

In the NHS-Social Care Interface dashboard, Darlington is ranked 15 out of 150 local authority areas for DToC for 18+. This puts Darlington in the top quintile of this metric as ranked across the NHS-social care interface dashboard. There are, still, however, areas around the pathway that require improvement and these improvements will be implemented during 2017/18, supported by the iBCF Grant.

A pilot "Discharge to Assess" service, with twice-daily a multi-agency on-ward meeting, was started in November 2017 with a number of objectives including reduced Length of Stay in the Acute Setting; reduced DTOC bed days, reduced avoidable inpatient spend, improved patient experience, maximised independence, delaying and preventing need, and assessments are accurate and the support provided is appropriate to need – not too much or too little.

The pilot is under evaluation against metrics including reduction in avoidable emergency readmissions, greater involvement of the VCSE in supporting discharge, support to carers in support of successful discharge.

Health and LA partners have worked together over a number of years on discharge planning and delivery and are approaching the "mature" stage in terms of change 3 (Multi-disciplinary discharge teams) and Change 8, enhancing health in care homes (ref BCF Exchange Case Study on Darlington's community matrons). Social Care staff participate in twice daily on-ward huddles and have an escalation process in place to facilitate discharge where necessary. They have very well established relationships with patient flow teams at the hospital, robust communications, and social care staff participate in the weekly regional OPEL teleconferences. The hospital has been trialling a number of initiatives to bring discharge readiness to the front of patients and their families' minds at the point of arrival, and these will be formalised during 2017/18 and overseen by the Local Discharge Delivery Board, comprising partners to discharge from adult social care, County Durham and Darlington Foundation Trust, Darlington CCG.

A rapid response service implemented over winter proved very effective and allowed discharge to assess to function well, along with seven day working.

The Local Discharge Delivery Board will carry out a self-assessment against the eight changes in the high Impact Change model and developing a plan, with the intention of maintaining our current good DToC performance, delivering the targets set out in the DToC metric and preserving our existing good relationships.

The re-procurement of the Home Care and Support Contract under a revised model will provide additional capacity within the domiciliary care sector in Darlington, as well as providing market stability and develop provider resilience. Under the new model, there are two “Lots” (East and West) with a prime provider in each area, delivering all non- specialist support. It is also anticipated that an added benefit of having one main provider in each geographical area will contribute to the development of community networks

The pivotal role of reablement in discharge planning and admissions prevention was the subject of a review of intermediate care services during 2016/17.

The review concluded that the service appears to work well with a combination of social care and health staff working alongside each other to appropriately manage the demands of the people of Darlington from a variety of settings. Based on discussions with staff from both organisations and descriptions of the working practices, this team is able to try and ensure that the most appropriate support or care is offered to individuals to meet their needs.

Domiciliary Care, Healthcare Services in Care homes and personalised healthcare at home

This strand brings together and builds on a number of initiatives introduced in BCF 2015 to help maintain independence among frail elderly people at home, reducing and delaying admission to 24 hour care, reviewing how domiciliary care packages and support is commissioned to better support people at home.

Roll-out of “Just Checking” Assessment tool as part of the pre-assessment of people contacting Adult Social Care has had a very positive impact in, for example, the number of overnight support packages commissioned. A full review of impact is due at the end of August 2017.

Permanent admissions to residential care have reduced for the second year running. Actions and changes lying behind this direction of travel include:

- Changes to how Darlington BC operates its Validation Forum and the emphasis on strength-based assessment against Care Act criteria.
- Improved, and more targeted use of Extra Care housing
- A focus on short break stays and close monitoring of the reasons they are commissioned
- Use of the Just checking Assessment tool to support a decision as to whether overnight support is necessary - often a tipping point for a residential admission.

Darlington received national recognition through a case study by Optimity consultants, on the Better Care Fund forum. Building on the nationally recognised outcomes arising from will continue with the objective of improving and supporting the health of care home

residents and reducing unplanned/unnecessary admissions to hospital from care homes, and reducing any delay in a person returning to their home after a hospital stay. The Case study is at Annex 2.

Care Navigation (Long Term Conditions)

This work started in 2015 to address a range of issues around the clarity of pathways for diagnosis in Primary Care leading to varying levels of referral, communication with patients (including high levels of avoidable contact), care planning, multiple appointments and duplication. It aimed to resolve inconsistencies in referral, provide more patient information earlier in the pathway, and introduce care planning for this cohort.

The project came to a close this year, having delivered care planning for the identified cohort (rollout from April 2017), the introduction of a breathlessness algorithm for GPs, Improved patient information, cross skilling of community nurses, improved LTC & MH awareness in Primary Care, and a comprehensive programme of Health Coach training.

Successes

Care Homes

Darlington received national recognition through a case study by Optimity consultants, on the Better Care Fund forum. Building on the nationally recognised outcomes arising from will continue with the objective of improving and supporting the health of care home residents and reducing unplanned/unnecessary admissions to hospital from care homes, and reducing any delay in a person returning to their home after a hospital stay.

Non-Elective Admissions

Permanent admissions to residential care have reduced for the second year running. Actions and changes lying behind this direction of travel include:

- Changes to how Darlington BC operates its Validation Forum and the emphasis on strength-based assessment against Care Act criteria.
- Improved, and more targeted use of Extra Care housing
- A focus on short break stays and close monitoring of the reasons they are commissioned
- Use of the Just checking Assessment tool to support a decision as to whether overnight support is necessary - often a tipping point for a residential admission.

Delayed Transfers of Care

In the NHS-Social Care Interface dashboard Darlington is ranked 15 for DToC for 18+.

6. Performance against the National BCF Metrics in 16/17

As part of the requirement for the BCF 17/19 submission, outlined below is the 16/17 performance in relation to the BCF National metrics:

Non Elective Admissions: Total non-elective admissions into hospital per 100,000 population

Non-Elective Admissions (General and Acute)		Published data				
		2016/17*				
		Q1 2016/17 (Apr16-Jun16)	Q2 2016/17 (Jul16-Sep16)	Q3 2016/17 (Oct16-Dec16)	Q4 2016/17 (Jan17-Mar17)	Total
Darlington HWB	Numerator (Actual)	3189	3208	3293	3234	**12924**
	Numerator (Plan)	*3245*	*3181*	*3232*	*3170*	***12828***
	% Variance to same quarter of previous year	+2.8%	+3.7%	-4.9%	+0.5%	+0.3%

Delayed Transfers of Care (DToCs) Delayed Transfers of Care: Delayed transfers of care from hospital per 100,000 population (days delayed)

Delayed transfers of care from hospital per 100,000 population (18+)	2016/17			
	Q1 2016/17 (Apr16-Jun16)	Q2 2016/17 (Jul16-Sep16)	Q3 2016/17 (Oct16-Dec16)	Q4 2016/17 (Jan17-Mar17)
Quarterly Rate (Actual)	**624.6**	**652.2**	**725.4**	**443.4**
Quarterly Rate (Plan)	***702.6***	***684.6***	***666.6***	***647.1***
Numerator (Actual)	520	543	604	370
Numerator (Plan)	*585*	*570*	*555*	*540*
Denominator	83260	83260	83260	83455

Proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation services

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) - ASCOF measure 2B(1)		Published ASCOF 2B(1) Data	Local Data	*Variance against Plan*
		2015/16	2016/17	*2016/17*
Darlington LA	%	**76.7**	**77.3**	-2.7%
	Numerator	135	116	
	Denominator	176	150	

The reablement service was reviewed in 16/17 and an improvement plan is now being implemented with the support of reablement consultant Gerald Pilkington.

Permanent Admissions to Residential and Nursing Care Homes

Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population - ASCOF measure 2A(2)		Published Data	Published Numerator	Local Data	BCF Plans		Variance from Plan	
		2014/15	2015/16	2016/17 PROVISIONAL ONLY	*2015/16*	*2016/17*	2015/16	2016/17
Darlington LA	**Rate**	**788.4**	**842.6**	**765**	***925.5***	***812.8***	-82.8	-47.8
	Numerator	159	173	160	*190*	*170*	-17	-10
	Denominator	20170	20530	20915	*20530*	*20915*	-	-

Permanent admissions to residential care have reduced for the second year running. Actions and changes lying behind this direction of travel include:

- Changes to how Darlington BC operates its Validation Forum and the emphasis on strength-based assessment against Care Act criteria.
- Improved, and more targeted use of Extra Care housing
- A focus on short break stays and close monitoring of the reasons they are commissioned
- Use of the Just Checking Assessment tool to support a decision as to whether overnight support is necessary - often a tipping point for a residential admission.

Local Metric (TBD) Dementia diagnosis: Estimated diagnosis rate for people with dementia

Estimated diagnosis rate for people with dementia - ages 65+ (E.A.S.1)	as at July 2017	
	Darlington	England
Percentage	79.2%	68.0%
Recorded Diagnosis of Dementia (Ages 65 + only)	1,060	434,839
Estimated Dementia Prevalence (Ages 65 + only) CFAS II	1,339	639,473

Diagnosis in Darlington is 11.2% higher than the overall diagnosis rate for England.

7. Evidence base and local priorities to support plan for integration

The Darlington BCF plan will look to support the shift towards improving 'population health and wellbeing' - moving from fragmentation to integration in care delivery, but also tackling the wider determinants of the health and wellbeing of our population.

Building on the success of 15/16 and 16/17 the 17/19 BCF plan aims to deliver through partnership working a plan of action to support future health and social care integration opportunities to address the local needs of the population.

The issues this BCF plan aims to impact (to be reviewed when plan is finalised)

Issue	Challenge	Action
Good performance against emergency admissions (65 and over) metric	To maintain the direction of travel in respect of 65+ NEA	Work with the CCG Business Intelligence Unit to identify continued areas of trend to better understand impact on BCF funded schemes and CCG commissioned services to inform future commissioning plans. Contribute to the CCGs Quality Innovation Productivity Prevention programme to deliver the proposed CCG Non-elective trajectory. Scope early intervention and intermediate care services across Health and Social Care to determine new model of care to support non-elective activity.
Good performance against Length of Stay for emergency admissions (65 and over)	To maintain the good performance in the context of system change	Work with the CCG Business Intelligence Unit to identify areas of variation and over performance across clinical pathways in relation to excess bed days. Build on the discharge to assess model to support discharges, as set out above. Work closely with the Acute Trust

		to ensure delivery of the supportive, proactive and safe discharge 2 year CQUIN scheme.
We have poor performance in terms of weekend discharge delays	To increase the number of patients discharged on a weekend following an emergency admission (over 65s)	Work in partnership across Health and Social Care to determine services (in and out of hospital) required to support and improve weekend discharges. Build on the discharge to assess model to support discharges set out above to address the delayed transfers of care.
Good performance against total delayed days per 100,000 metric	To maintain the good performance in contributing to reducing hospital delayed discharge days	Jointly commission a fully integrated discharge team across health and social care. Improve patient discharge pathways promoting a 'home first' concept Agree one joint assessment and care planning as part of the discharge process. Roll out the trusted assessor role across discharge pathways Reduce the number of CHC assessments undertaken in the acute setting. Improve the weekend discharge pathway Monitor current pilot scheme to ensure effectiveness as part of transfers of care work
Poor performing on the proportion of people 65 and over who are still at home 91 days after discharge from hospital into reablement /rehabilitation services	To improve the number of people (65+) who are still at home 91 days after discharge from hospital into reablement/rehabilitation.	Deliver a **comprehensive improvement and delivery plan** for reablement and intermediate care services. • Improved pathway • Improved data collection and analysis on a day to day basis • Clearer eligibility criteria

		Further analysis of reasons why people are not still at home after 91 days. Better targeting of reablement resources. Development of integrated approach to intermediate care, which will include reablement.
Growth of over 65 population with long term conditions and the impact on health and social care services by 2020.	Reduce impact of long term conditions and promote self management and self care.	Increased focus on equipping people to be resilient and self-reliant through: • Social prescribing and supporting the VCSE • Continued promotion and development of Hartlepool Now • Digital care solutions • Further integration of services to reduce duplication and ensure that resources are used effectively across health and social care to manage increasing demand.
Adult Health and Social Care Market	Support the development and sustainability of a vibrant market for health and social care	Maintain positive working relationships with the market to understand and anticipate pressures and influence market shaping Use of iBCF to support sustainability of the care market. Care Quality Improvement Programme. Maintain positive working relationships with the market to understand and anticipate pressures and influence market shaping.
Reducing resource across the health and social care services	Maintaining and improving current services for those with eligible needs while supporting the wider population to become	Use of iBCF to support adult social care Use of iBCF to reduce pressure

	resilient and take personal responsibility for their own health and wellbeing.	on the NHS through new models of care Improve information, advice and signposting that support people to maintain their health, wellbeing and independence without input from statutory services. Further integration of services to reduce duplication and ensure resources are used effectively across health and social care to manage increasing demand •

8. Better Care Fund Plan 17/19

The Better Care Fund Plan 2017/18 seeks to build on foundations laid in 2015/16 and 2016/17 in the areas of admissions avoidance in 65+, a joint approach to discharge management, reablement and intermediate care services, improving health in care homes, and building a robust community and universal services offer in support of managing demand into the future.

Reablement data indicates only a small improvement in effectiveness which will be addressed through an improvement plan.

The Local Authority and health partners have been working together on discharge planning and delivery for a number of years and have a robust relationship that facilitates productive patient flow.

A rapid response service implemented over winter proved very effective and allowed discharge to assess to function well, along with seven day working.

The BCF plan for 17/19 will seek to build upon the successes of previous BCF plans in the areas of seven broad workstreams as outlined below:

- New Models of Care and personalisation of services including through technology and domiciliary care;
- Healthcare services to Care Homes;
- Equipping people to be resilient and self-reliant through Primary Prevention/Early intervention, and Care Navigation;
- Intermediate Care and improvements to reablement and rehabilitation services;
- Further improving Transfers of Care through the implementation of the High Impact Change Model,
- Supporting carers and delivering DFG adaptations;
- Improving Dementia Diagnosis and post diagnosis support.

<u>New Models of Care</u>

A key programme currently in development will build on the outcomes of the Discharge to Assess model piloted in 16/17 and further implement the High Impact Change Model. This has the capacity to impact on intermediate care and the use of social care “short stays”. Also under this umbrella are elements of domiciliary care, personalisation of services use of telehealth and technology, and the pathways for people to “step up” social care and reablement and avoid admission into care homes or hospital. The STP outlines the intention to work with GP practices who will be brought together into groups of practices called ‘community hubs’ so they can share their skills to match the needs of local residents.

<u>Care Homes Support</u>

A range of health-focused activities to ensure residents have consistent healthcare and avoid unnecessary admissions to hospital. This links with discharge planning and the “step-down” pathway. A Care Home Commissioning Group has been established, to aid closer working of health and social care commissioners to support the residential care sector.

Commissioning outwith the BCF in support of improving the health of Care home residents include the availability of Medication Optimisation Pharmacists, and the infection control team.

Primary prevention and care navigation - equipping people to be resilient and self-reliant

A social prescribing test bed, trialling a primary prevention approach, and supporting care navigation, got under way in May 2017, with Wellbeing navigators appointed from the voluntary and community sector, building on experience gained through the MDT approach at GP Practices, and will be monitored as part of BCF 2017/19. Measures of success include client outcome monitoring, breadth of services referred to (resilience of the VCSE sector), quantification of the service need and appropriate entry criteria. Aligned to this is the development and provision of a comprehensive directory of Service for Darlington, a web based service containing information about major providers through to very small community groups, allowing people to find their own provision, and for first points of contact, care navigators and other advocacy services to find suitable options for people below the eligibility or treatment threshold.

Dementia

A report into dementia commissioned by the Adult and Housing Scrutiny Committee provides the basis for planning new or different dementia services as part of BCF 2017/19. A scheme specifically targeting support for people within the BME and LGBT communities is being developed to start in 17/18, and a second scheme delivering games for the brain, singing for the brain, and swimming for people with dementia will be commissioned.

Intermediate Care

The RIACT and intermediate care service is central to helping keep people out of hospital, and for speeding their journey home if they have had to be in hospital, aiming to provide therapy, nursing care, or domiciliary support in the community to help a person regain optimum independence. At the same time, the health and social care landscape within which the service operates is changing quite rapidly in Darlington as more and more multi-disciplinary teams come together at different stages in the patient pathway, driven by different partner priorities. We need to have a service that delivers and can evidence effective support, has clear connections with referrers and discharge destinations, and that can flex and accommodate a perpetually shifting landscape.

An external review commissioned in Q3 16/17 has begun to identify what might need to change in terms of the intermediate care operating model, and the way the parts of intermediate care work together, to make the most effective contribution to Darlington people's health and care support. This improvement plan, currently being developed, will be delivered as a key pillar of BCF 2017 – 19 and is intended to address, among other objectives the relatively poor performance of Darlington on the effectiveness of Reablement metric from under eighty per cent to the realm of the top performers, in the nineties over the next two years

Transfers of Care: High Impact Change Model

Patient flow and discharge planning is pivotal, and work to implement the high impact changes will continue. The Local Authority and health partners have been working together on discharge planning and delivery for a number of years and are probably at the "mature" stage in terms of Change 3 (Multi-disciplinary discharge teams) and Change 8, enhancing health in care homes (ref BCF Exchange Case Study on Darlington's community matrons). Social Care staff participate in twice daily on-ward huddles and have an escalation process in place to facilitate discharge where necessary. There are established relationships with patient flow teams at the hospital, robust communications, and social care staff participate in the weekly regional Operational Pressures Escalation Levels Framework (OPEL) teleconferences. The hospital has in place "your ticket home" to ensure discharge is discussed as soon as possible after admission.

However, we are ranked poorly in the NHS-social care interface dashboard for weekend discharge, with just over 18% of discharges taking place at the weekend, compared with 22% for the best performers. This is a known issue to be resolved through the partnership working established.

We will jointly be carrying out a self-assessment against all eight changes and developing a plan, with the intention of maintaining our current good DToC performance, delivering the targets set out in the DToC metric and preserving our existing good relationships. A specific discharge group for Darlington is in place to further progress the work.

The CCG and partners will continue to build upon the principles, learn from the work to date and develop integrated approaches to further impact on delays and improve the patient experience.

Use of iBCF

Darlington Borough Council is ranked seventh in respect of delays to social care related transfer of care on the NHS-social care interface dashboard. The Council is also a high spending authority by comparator group in terms of per-head of population expenditure on social care. These two circumstances are linked.

The new grant funding will be used to offset expenditure on current pressures and demand to ensure sustainability while the service undergoes transformation, also funded through iBCF. This will reduce the immediate ASC budget pressure and achieve a more financially stable position for ASC in the medium term when a transformed service can operate sustainably within its resources.

The iBCF will be used to support key local priorities to ensure the sustainability of the local care market, protect adult social care services that would otherwise be subject to significant cuts and reduce pressures on the NHS through new models of care.

The first quarterly return on iBCF is at Annex 3.

Managing current pressures

Retaining the current focus on transfers of care will support the continuation of positive DToC performance, and help mitigate any impact that might arise from changes elsewhere

in the system. In particular, targeting “upstream” activity to reduce the likelihood of admissions is proposed as a key plank of the strategy.

Embedding strength-based assessment/support planning, by increasing capacity in the review team, is an area that will improve an individual’s independence, ability to self-care and reduce the potential for future service need.

Short stay bed usage avoids admission to hospital (step-up) and facilitates transfers of care (step-down), but it represents a budget risk which the grant can mitigate. This usage also supports the wider BCF condition 2 (being additional to the NHS contribution to adult social care, maintained in line with inflation) and condition 3, agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care.

Domiciliary care packages support admission avoidance to hospital and facilitate transfers of care. As with short stay beds, this is a significant area of activity that represents a budget pressure that is unsustainable without additional investment.

Supporting the transformation of Care and Support

Darlington Borough Council is amidst its transformation programme. This is designed to deliver an efficient and effective model of ASC that is able to manage the projected increases in demand resulting from demographic pressure and complexity of needs.

The programme is underpinned by a strength based approach that will help people to achieve their full potential for self -care and independence and maintain it for as long as possible.

Developing such a model is essential to the health and social care system and will divert pressure from local NHS services. Allocating grant funding will add capacity and speed of delivery in key areas.

Using additional Winter Pressure funding a pilot Rapid Response and Overnight Sitting Service was commissioned from an already contracted provider. The service ran between December 16 and May 17 and delivered support to individuals being discharged from hospital for up to 48 hours, to allow for a more permanent support package to be arranged. The provider was also able to provide overnight support for those individuals who required it. A full evaluation of this pilot demonstrated the value of the service and recommended that it is procured on an ongoing basis .

Key areas of social care transformation

Reablement is fundamental to an effective health and social care system and is central to achieving priority outcomes. Reablement helps people to achieve their optimal level of independence and capacity for self- care. It prevents, reduces and delays the need for formal services including hospital admissions. Improving the reablement pathway will contribute to reducing NEA and maintenance of good DToC performance. It will introduce more ‘step up’ capability and strengthen the social care contribution to partnership working in the areas of hospital discharge and Teams Around Practices.

The New Model of Care (see figure 1) currently being proposed by the CCG presents the opportunity to align staff around real or virtual hubs to support effective multi-disciplinary working and the delivery of integrated care around the person.

The use of technology and assistive tools, particularly in respect of falls prevention. A fall is often a trigger event for reduced independence and often results in unnecessary permanent care home admissions. The use of assistive technology will become a default offer that will maximise self-care and independence.

The implementation of online systems to provide people with tailored information, advice and guidance and effective sign posting to community and voluntary sector services.

Transformation objectives include the aspiration to develop service capability across the week in specific areas of the social care pathway. This will improve the availability of the social care skill set within RIACT and the interface with health partners. This will support discharge to assess initiatives and the implementation of trusted assessor approaches.

Some specific, targeted and defined capacity to support transformation as a whole: policies and systems to support new ways of working, support to get the most from the social care pathway, support with diagnostics and additional capacity for the Review Team, as mentioned above.

Use of Disabled Facilities Grant (DFG) Funding

The use of DFG funding to purchase a range of additional units of assistive technology will ensure that where overnight support is indicated for some individuals, the assistive technology (Just Checking) is deployed as the first response. The data produced from the sue of this equipment will act as an aid to social care assessments and ensure a more appropriate and cost effective support plan is developed. The technology is also being utilized within residential care settings to monitor the support needs of individuals placed there on a “short break stay” , to help determine if, and how best to support these individuals to return home.

DFGs Completed 2016/17					
Type of Adaptation	Under 18	18-39yrs	40-64 yrs	65- 80 yrs	80+ yrs
Straight Stairlift	0	0	5	8	6
Curved Stairlift	0	1	1	6	4
Extension	1	0	1	0	0
Level Access Shower	2	3	7	19	14
Over Bath Shower	0	1	0	0	0
Ramp	2	0	4	5	5
Other	0	0	0	3	0
Total	5	5	18	41	29

9. Risk

The BCF risk log identifies a range of risks associated with delivery of the BCF plan and the mitigating actions in place.

There is a risk that:	Likelihood	Potential impact	Overall risk factor	Mitigating Actions
There is insufficient information and data at the correct level and quality to effectively monitor outcomes and ensure overall delivery of the BCF plan.	1	3	3	• Health and social care information teams work together to ensure that information is collected and presented meaningfully to inform planning and service development. • BCF work streams provide assurance that existing and planned developments deliver required outcomes. Reviews are undertaken to refine plans and there is potential to disinvest in schemes that fail to deliver outcomes • National performance measures are used where appropriate and where these are not available, locally agreed indicators are developed.
The schemes are not in line with existing NHS or LA delivery plans undoing existing good practice.	1	4	4	• Partners continue to be involved in development of BCF plans to ensure that organisational plans are aligned. • The agreed governance arrangements ensure that the impact of decisions relating to BCF implementation are considered by all partners on the Pooled Budget Partnership Board. • Plans build on the good practice already in place prior to BCF.
There is insufficient time for schemes to have the impact in the short term on performance and savings.	2	4	8	• Plans build on existing good practice. • Existing services will contribute to delivery of the BCF plan. • Contractual mechanisms are used where appropriate to ensure that changes are delivered within agreed timescales.
As current funding to social care is reduced there will be a	4	5	20	• Funding to maintain social care provision has been agreed and

There is a risk that:	Likelihood	Potential impact	Overall risk factor	Mitigating Actions
detrimental impact on the delivery of savings and BCF outcomes.				secured for 2016/17 at the same level as 2015/16 but is not sufficient to manage the impact of local government funding cuts. • The Pooled Budget Partnership Board will continue to monitor the impact of changes to social care funding and risks posed to the BCF. • Darlington LA iBCF plans are designed to support the current position while transforming the service to be sustainable by 2021.
Workforce skill mix and availability to deliver the new pathways of care is not adequate.	3	4	12	• Workforce planning and development with Health Education North East and NHS England Local Area Team continues. Difficulty recruiting nurses across the health and social care system remains a challenge.
Shifting resources to fund new integrated services destabilises current providers, particularly in the acute sector.	2	4	8	• This has been managed successfully to date and will continue to be reviewed regularly.

Risk Share/Contingency Arrangements

Management of risk is as set out in paragraph 12 and Schedule Three of the s75 agreement. In summary:

12 Risk share arrangements, Overspends and Underspends

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for financial risks arising within the commissioning of services from the Pooled Funds and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to detailed included in Schedule 3, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial

Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 In the event that the Pooled Fund Manager identifies an actual or projected Overspend, the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule (3) shall apply.

12.4 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.3.

Overspends in Non-Pooled Funds

12.5 Where in Joint or Aligned Commissioning Arrangements either Partner forecasts an overspend in relation to a Partner's Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

12.6 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Partnership Board of any projected or actual overspends.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

12.8 In the absence of specific Agreement to the contrary set out in the Service specifications, underspend on any Pooled Fund will be distributed to each Partners in proportion to its Financial Contribution to the Pooled Fund.

12.9 The Partners may agree to carry forward to the following Financial Year any underspend on any Pooled Funding order to contribute to the Pooled Funding the following year, subject to an Agreement to extend the term of the Agreement.

Risk share over-arching principles

Darlington Borough Council, NHS Darlington Clinical Commissioning Group, are committed to joint working and the implementation of integration principles referred to in the Health and Social Care Act 2012, as part of the Darlington health and social care integration programme.

Darlington Council and NHS Darlington Clinical Commissioning Group have agreed to collaborate on ensuring robust arrangements for the management of financial risk and gain.

Risk Share Arrangements, Overspends and Underspends

Risk share arrangements are required to deal with overspends and underspends. Potential overspends should be identified by the scheme Pooled Fund manager and reported by them to the Pooled Budget Partnership Board, who will decide what action to take to deal with the overspend.

The table below sets out how the Partners will; deal with overspends and underspends in current Service Contracts that are included within the scope of the Individual Schemes

Risk share	Investments	Benefits
Overspend	The Council will be responsible for the overspend that takes place in Individual Schemes for which it is Lead Commissioner. The CCG will be responsible for the overspend that takes place in Individual Schemes for which it is Lead Commissioner. .	The Council will assume the loss of benefits associated with overspend for the Individual Schemes for which it is Lead Commissioner. The CCG will assume the loss of benefits associated with overspend for the Individual Schemes for which it is Lead Commissioner.
Underspend	The Council will be responsible for the underspend that takes place in Individual Schemes for which it is Lead Commissioner The CCG will be responsible for the underspend that takes place in Individual Schemes for which it is Lead Commissioner .	The Council will assume the benefits associated with underspend (dependent on meeting minimum performance criteria) for the Individual Schemes for which it is Lead Commissioner. The CCG will assume the benefits associated with underspend (dependent on meeting minimum performance criteria) for the Individual Schemes for which it is Lead Commissioner.

10. National Conditions

National Condition 1: Jointly Agreed Plan

The Better Care Fund plan has been jointly developed by partners; specifically:

- Darlington Borough Council
- Darlington CCG
- County Durham and Darlington NHS Foundation Trust
- Tees Esk and Wear Valley NHS Foundation Trust

This joint planning enables partners to develop services that will contribute to reducing pressures on urgent care and prevent people needing emergency care in hospital or a permanent care home admission. It is expected that this will continue in 2016/17 and beyond as part of wider transformation plans (STP).

The BCF Plan including minimum budget and performance measures was developed jointly by Darlington UA and Darlington CCG, and signed off by the Health & Wellbeing Board on September 7 as required by the submission and assurance process. The Health and wellbeing membership is very broad and includes local providers, CDDFT, TEWVFT, housing, education, and other public services along with the VCSE.

The additional social care grant (iBCF) was agreed in principle by the BCF Pooled Budget Partnership Board in August 2017, and then by the Health and Wellbeing Board in September. The iBCF will be used to support the adult social care core offer while transformation work over the next two years delivers a sustainable service able to respond to demographic changes.

All BCF quarterly returns will approved through the BCF Pooled Budget Partnership Board. It was recognised that the dates of returns and Health and Wellbeing Boards did not always coincide, so the HWB Board formally delegated authority to sign off returns at its September meeting.

The Health & Wellbeing Board includes representation from the two Foundation Trusts (FTs) that deliver the majority of NHS services locally, and both FTs are also represented on the Integration Board.

The DFG allocation will be used to continue funding adaptations that support people to live independently in their own homes. Use of the DFG allocation is reported to the BCF Pooled Budget Partnership Board on a quarterly basis.

DFG is deployed through the local home improvement agency by Darlington Borough Council which is a unitary, so no transfer of funds is required.

National Condition 2: social care maintenance

BCF Expenditure on Social Care from Minimum CCG Contribution	2016/17	2017/18	2018/19
Planned Social Care expenditure from the CCG minimum	£2,332,554	£2,374,307	£2,419,419

In Darlington, maintaining provision of adult social care means ensuring that people with eligible social care need continue to be supported. The focus is on managing demand and maximizing independence, providing information

There is an increase in planned spend on social care from the CCG minimum for 17/18 and 18/19 equal to the amount confirmed in the planning template. Planned contributions do not exceed the minimum, and partners work together to ensure that any change does not destabilise the local care system as a whole. The amount spent on social care services has positive impact on health, as can be seen in the list of schemes and planned outcomes in the plan.

National Condition 3: NHS commissioned out-of-hospital services

The minimum allocation for NHS Commissioned out-of-hospital services has been committed as set out in the planning template and in line with the Darlington CCG Operational Plan.

The Financial Summary in the planning template shows that there is an investment in NHS Commissioned out of hospital services of £4,085,843. This is broken down by:

Out of Hospital Investment	Darlington
Community Health	£3,276,562
Mental Health	£349,159
Social Care	£218,115
Other	£ 242,007
Total	**£4,085,843**
Minimum contribution required	£2,104,130

The local area's share of the £1 billion previously use for the payment for performance set out in the BCF Allocations is £4,085,843 . This shows that there has been a greater investment in NHS Commissioned out of hospital services of £1,981,713 than the minimum required.

National Condition 4: Managing Transfers of Care

Darlington's Local Discharge Delivery Group - comprising FT, CCG and ASC– will oversee self-assessment against, and further implementation of, the high impact change model and resolve issues:

- the use of Community step down beds
- the weekend discharge pathway

Elements of the model have already been adopted: the Local Authority and health partners have been working together on discharge planning and delivery for a number of years and are probably at the "mature" stage in terms of change 3 (Multi-disciplinary discharge teams) and Change 8, enhancing health in care homes (ref BCF Exchange Case Study on Darlington's community matrons). Social Care staff (funded through BCF) KLOE 13 participate in twice daily on-ward huddles and have an escalation process in place to facilitate discharge where necessary. We have very well established relationships with patient flow teams at the hospital, robust communications, and social care staff participate in the weekly regional OPEL teleconferences. The hospital has in place "your ticket home" to ensure discharge is discussed as soon as possible after admission.

The CCG is also working closely with the Trust on the new Supportive Proactive and Safe Discharge CQUIN should also support the proposed reductions, this two year CQUIN aims to improve patient outcomes, improve patient flow and reduce delayed discharges. In year one (17/18) acute providers are required to:

- Map existing discharge pathways, roll-out new protocols, collect baselines/trajectories
- Increase the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% from baseline (Q3 and Q4 2016/17)

In year 2 (18/19) providers are required to:

- Increase the proportion of patients admitted via non-elective route discharge from acute hospitals to their usual place of residence within 7 days of admission by 7.5% from 2017/18.

11. Overview of funding contributions

Funding sources	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Darlington CCG	£7,404,433	£7,545,117
DFG	£804,133	£868,491
iBCF	£2,352,800	£3,156,213
	£10,561,367	**£11,569,821**

Care Act 2014 Monies

£293k was identified from the BCF pooled budget in 2017/18 to support implementation of the Care Act duties. This funding will be maintained in 2017/19 and will continue to support staffing costs associated with undertaking additional social work and related assessments, costs associated with the statutory Safeguarding Adult Board and new duties relating to information, advice and advocacy.

Reablement Funding

Reablement Funding continues to support a range of services including Darlington's RIACT and reablement service, provided jointly by the Local Authority and Community Health, and providing step up and step down beds in the community, and Community Hospital services. This funding continues to support safe and timely hospital discharges with services focused on maximising independence and reducing the risk of readmission to hospital.

Carers Funding

Funding identified for carers' breaks is £111,000 in total, and comprises:

- £38,500 to deliver a number of carer support groups, activities and personalised breaks for both adult and young carers, including trips, social events and health and wellbeing days and a prepare for work programme;
- £60,500 to a number of local 3rd sector providers to provide: respite befrienders for older carers; play scheme places for disabled children and young people; groups and activities for carers of people with dementia and counselling services for carers.
- £12,000 has been transferred to Adult Social Care to support the provision of additional breaks for carers.

Breaks for young carers are funded £75,625 in 2017/18 and £82,000 in 2018/19.

£101,750 is allocated in 17/18 for support to carers, rising to £111,000 in 18/19.

Social Care

As outlined in relation to National Conditions, the allocation from the BCF to support maintenance of adult social care services in 2017/18 is £2.379m and in 18/19 £2,424m. Schemes against which this is allocated, and the out of hospital services funding, are set out in the planning template. KLOE 25

iBCF

As outlined earlier in the document, and evidenced in the monitoring report attached the iBCF will be used to support the core adult social care offer and accelerating the pace of transformation of the service, so that a sustainable level of service is in place by 2020.

12. Programme Governance

Robust governance arrangements for the Darlington Better Care Fund Plan have been in place since 2014/15. These governance arrangements reflect the partnership approach that is required to effectively deliver the integrated approach described in the Better Care Fund Plan but also acknowledge the needs of individual partner organisations to ensure that decisions are taken through their own internal governance arrangements. The agreed governance arrangements ensure that a system wide perspective and approach is taken through the relevant decision making groups.

The diagram below sets out the governance arrangements for the Darlington Better Care Fund (BCF) programme for 2017-19.

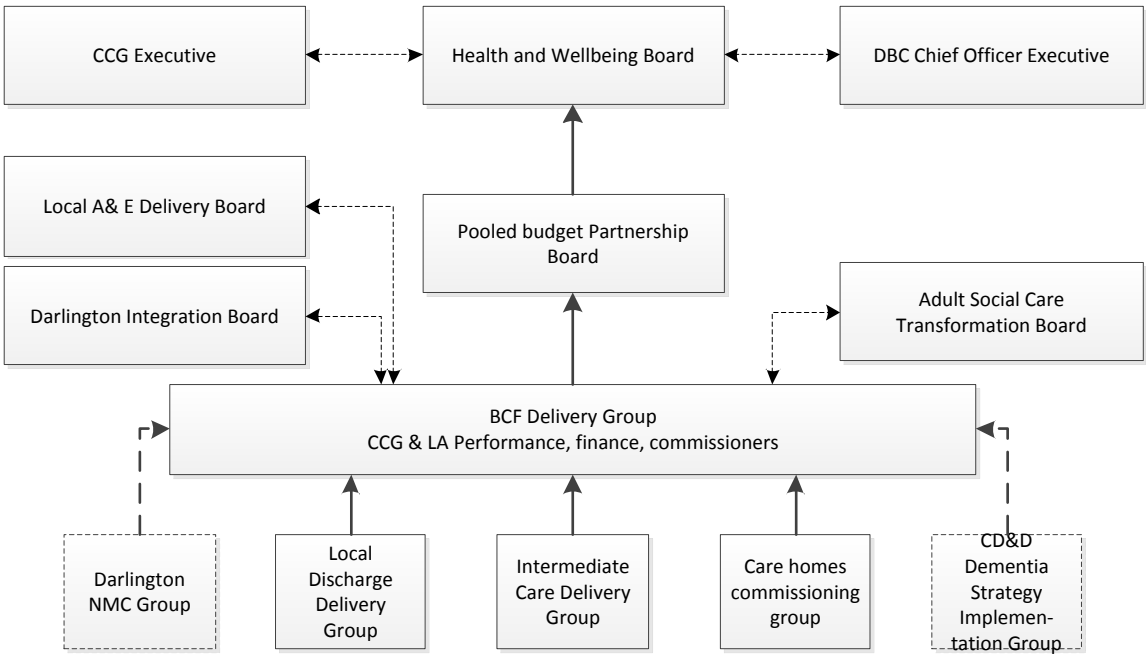


Chart 1 Programme Governance 2017-19

Working Together: governance and accountability

Partners in health and social care in Darlington have a track record of close working together on patient flow and discharge planning, reablement and intermediate care, carers' support and other areas, and this will continue. The New Model of Care will provide the opportunity for further colocation, integration and grouping services round people in localities.

A structure of joint governance groups ensures continued oversight from all partners, with the Health and Wellbeing Board at the top.

Health & Wellbeing Board Governance

The Darlington Health & Wellbeing Board is responsible for; signing off and ensuring delivery on the Darlington Better Care Fund Plan; ensuring that the BCF plan responds to local needs, is aligned with the Health & Wellbeing plan and supports system integration across health and social care; agreeing the use of funding under the Better Care Fund pooled budget arrangements; addressing any risks and issues arising that relate to the wider Hartlepool health and social care system; and progressing any joint commissioning implications and requirements arising from the Better Care Fund.

The Darlington Integration Board brings together key partners to provide strategic leadership and oversight to the development and delivery of the Darlington Better Care Fund Plan, ensuring alignment with wider strategic plans across health and social care and co-ordinating and aligning all cross-organisational activities across the health and social care.

The BCF Pooled Budget Partnership Board is the board established under the Section 75 agreement to oversee all the budget and performance matters relating to the Better Care Fund. The Board comprises chief officers and finance officers from Darlington UA and Darlington CCG and provides oversight and sign-off for all projects and provides the forum for agreeing expenditure and evaluating schemes, and an intermediate care delivery group and local discharge delivery board (commissioners and providers) oversee planning and delivery. All business cases and scheme reviews go to this Board for approval, which also makes decisions in respect of slippage or changes. The PBPB addresses risks and issues that might impact on the delivery of the Better Care Fund; agrees contingency and risk management arrangements in the event that planned schemes do not deliver to projections; coordinating and sharing how decisions will be taken within partner organisations; and supporting assurance processes.

The BCF Delivery Group is responsible for delivery of the Darlington BCF plan; developing new pathways and models of care; ensuring that partner organisations have taken decisions through their internal governance processes; ensuring each organisation provides sufficient resources to the work streams to ensure successful implementation of the programme; developing a joint communications strategy; resolving and appropriately escalating issues and risks associated with the Better Care Fund, including performance and finance; ensuring other groups are updated and assured of progress.

Delivery Groups are responsible for developing the pathways and models of care under each of the BCF schemes; resolving issues and risks which are within the remit of the project; developing the detailed implementation plans and taking day-to-day responsibility for implementation once the new pathways and models of care have been agreed.

Each of the partner organisations ensures that decisions are taken through their own internal governance structures and information is shared. For example the CCG Exec and Governing Body will be kept appraised of developments and informed of the progress of all plans; this is intended to be through development sessions and/or Governing Body

meetings. Member practices of the CCG will also be kept appraised through clinical time out events, Clinical Reference Groups and Council of Member meetings.

Benefits realisation

The Better Care Fund delivery group has management and control of schemes both from a national and local perspective, through robust performance management. (See table 1)

The performance management framework links with finance leads and through reporting to Pooled Budget Partnership Board provides the necessary scrutiny.

Learning and sharing

Darlington participates fully in the opportunities afforded by the regional support function, and participates in Better Care Exchange and the various webinars and support offers. We have shared case study material and will continue to do so.

Schemes review and evaluation – picking up under-performance

The BCF Delivery Group reviews all progress and ensures review dates and evaluation criteria are monitored. A monthly progress and exceptions monitoring system is in place:

13. National Metrics

Non-elective Admissions

The target set for NEL within the BCF plan is taken from the CCG 2017/18 Operational Plan. For Darlington CCG in 2017/18 this shows a 6.2% reduction from the 2016/17 levels with a further reduction of 8.6% in 2018/19 (detailed in the tables below):

FOT	
16/17	12,635
17/18	11,849
18/19	10,831

2017/18			
Annual activity actual numbers		-786	
Annual activity % change		-6.2%	
Apr-17	900	Q1	2,850
May-17	981		
Jun-17	969		
Jul-17	972	Q2	2,843
Aug-17	908		
Sep-17	963		
Oct-17	1,100	Q3	3,184
Nov-17	1,053		
Dec-17	1,031		
Jan-18	1,003	Q4	2,972
Feb-18	951		
Mar-18	1,018		

2018/19			
Annual activity actual numbers		-1,018	
Annual activity % change		-8.6%	
Apr-18	822	Q1	2,604
May-18	896		
Jun-18	886		
Jul-18	889	Q2	2,600
Aug-18	831		
Sep-18	880		
Oct-18	1,006	Q3	2,910
Nov-18	962		
Dec-18	942		
Jan-19	917	Q4	2,717
Feb-19	870		
Mar-19	930		

The figures provided in this table are from the CCG submitted plans which were calculated using 5 months actual and 7 months forecasted to give a 16/17 Forecasted out-turn from the data we held at the time. This will therefore differ from the 16/17 figures included in the BCF Plan as this uses the full year actual figures. There will also be slight differences when comparing CCG plans to BCF plans due to the CCG mapping which is applied when calculating the NEL activity figures in the BCF Planning Template.

The CCG have a history and proven track record of delivering planned reductions. As a result of this proven track record we feel justified in setting our ambition of non-elective reductions at the level we have. The Better Care Fund is one of the initiatives that will support the reduction in all non-elective (NEL) admissions; others include GP Variation and Rightcare.

The target for NEA is as set out in the CCG Operating plan; no additional target is set and consequently contingency funds are not linked to the cost of any additional non-elective admissions.

Admissions to residential care homes

Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population - ASCOF measure 2A(2)		Published Data	Local Data		*BCF Plans*		Variance from Plan	
		2015/16	2016/17	2017/18 (12 month rolling to May17)	*2017/18*	*2018/19*	2016/17	2017/18
Darlington LA	**Rate**	**843.3**	**768.0**	**756.8**	***816.0***	***785.2***	-48.0	-
	Numerator	173	160	160	*166*	*166*	-10	-
	Denominator	20515	*20833*	21141	*20833*	*21141*	-	-

Permanent admissions to residential care reduced for the second year running in 2016/17. Actions and changes lying behind this direction of travel include:

- Changes to how Darlington UA operates its Validation Forum and the emphasis on strength-based assessment against Care Act criteria
- Improved, and more targeted use of Extra Care housing
- A focus on short break stays and close monitoring of the reasons they are commissioned
- Use of the Just checking Assessment tool to support a decision as to whether overnight support is necessary - often a tipping point for a residential admission.

The target for 17/18 and 18/19 however, recognises that a continual fall in admissions is not achievable, given the projected increase in the population aged 70-74 of around 20% (just under 5000 to almost 6000) by 2021 on 2016 figures. This will be followed by an increase of 30% - 40% in the 75 - 80 cohort.

Effectiveness of re-ablement: How will you increase re-ablement?

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) - ASCOF measure 2B(1)		Published ASCOF 2B(1) Data	Local Data		BCF Plans		Variance from Plan	
		2015/16 (Q4 / Q3)	2016/17 (Q4 / Q3)	Q1 2017/18 (Q1 / Q4)	*2017/18*	*2018/19*	2016/17	2017/18
Darlington LA	%	**76.7**	**77.3**	**-**	***80.0***	***84.00***	-2.7	-
	Numerator	135	116	-	*200*		-84	-
	Denominator	176	150	-	*250*		-	-

Darlington BC and Darlington CCG are working together on improving reablement and intermediate care services, following a comprehensive review in 2016. The HWB area has not, in the past two years, attained the target of 80% of people over 65 who have had a period of reablement, being still at home 91 days later.

A joint improvement plan, owned by the Intermediate Care Joint Delivery group (a sub-group of the Pooled Budget Partnership Board) is currently in implementation, with external support. The improvement will cover the pathway, eligibility criteria, and specification for the service, as well as improving the use of business intelligence to ensure best value is achieved throughout. iBCF funding will be deployed to support transformation, and accelerate the implementation of identified changes which are likely to include, for example, a strengthened “step-up” offer into reablement as well as step-down, and the introduction of a functional assessment approach.

The target of 80% is held for this year in the expectation that the improvements being planned, and subsequently implemented, will be translated into improved outcomes, leading to a target of 84% in 2018/19.

Delayed Transfers of Care

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS No	0.0	0.0	0.0	112.0	111.0	108.0	112.0	107.9	111.5	111.5	100.7	111.5
ASC No				31.0	31.0	30.0	31.0	30.0	31.0	31.0	28.0	31.0
Joint No				0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total No	0.0	0.0	0.0	143.0	142.0	138.0	143.0	137.9	142.5	142.5	128.7	142.5
Pop.	83174	83174	83174	83174	83174	83174	83174	83174	83174	83286	83286	83286
RATE	0.0	0.0	0.0	171.9	170.7	165.9	171.9	165.8	171.3	171.1	154.5	171.1

NHSE provided guidance on what the expected level of DTOC's should be by Nov-17. This guidance also indicated the level of Social Care Delays they expected to see. The DToC trajectory we have submitted meets the overall target that has been set.

The trajectory set for Darlington requires the total number of delayed days to be below 139 by Nov-17. This is a slight increase from the Q4 position but will mean maintaining the reductions made since the Q3 position. We believe that through continued partnership working that this target is deliverable.

In 2018/19 the intention is to maintain the level required at November 2017.

The CCG is also working closely with the Trust on the new Supportive Proactive and Safe Discharge CQUIN should also support the proposed reductions, this two year CQUIN aims to improve patient outcomes, improve patient flow and reduce delayed discharges. In year one (17/18) acute providers are required to:

- Map existing discharge pathways, roll-out new protocols, collect baselines/trajectories
- Increase the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% from baseline (Q3 and Q4 2016/17)

In year 2 (18/19) providers are required to:

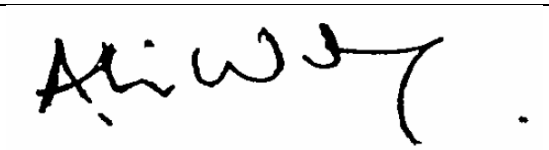
- Increase the proportion of patients admitted via non-elective route discharge from acute hospitals to their usual place of residence within 7 days of admission by 7.5% from 2017/18.

Local Metric (TBD) Dementia diagnosis: Estimated diagnosis rate for people with dementia

Estimated diagnosis rate for people with dementia - ages 65+ (E.A.S.1)	as at July 2017	
	Darlington	England
Percentage	79.2%	68.0%
Recorded Diagnosis of Dementia (Ages 65 + only)	1,060	434,839
Estimated Dementia Prevalence (Ages 65 + only) CFAS II	1,339	639,473

Diagnosis in Darlington is 11.2% higher than the overall diagnosis rate for England. Our local metric will be to maintain this good diagnosis rate with an ambition, through our scheme to improve diagnosis in BME groups, to increase that diagnosis rate to 80%.

14. Approval and sign off

APPROVAL – Final Submission: September 8 2017	
Name	Cllr Andy Scott (Chair) Darlington Health and Wellbeing Board
Signature	
Date	08/09/17
Name	Ali Wilson, Chief Officer Darlington CCG
Signature	
Date	11/09/2017
Name	Suzanne Joyner, Director Children and Adult Services Darlington UA
Signature	
Date	11/09/17

Annex 1: Pooled budget Partnership Board Terms of Reference

Pooled Fund Partnership Board – Darlington Borough Council and Darlington Clinical Commissioning Group

Terms of Reference

Membership

The membership of the Pooled Budget Partnership Board will be as follows:
CCG: (Accountable) Chief Officer, Chief Financial Officer, Director of Commissioning (or their deputies to be notified to the other members in advance of any meeting), and the pooled fund manager;
Council: Director, Children and Adult Services, Assistant Director Performance, Transformation and Commissioning (or their deputies to be notified to the other members in advance of any meeting), and the pooled fund manager

The Partnership Board will be chaired for six month periods by the CCG (Accountable) Chief Officer and the DBC Director, Children and Adult Services (or their deputies to be notified to the other members in advance of any meeting).

Partnership Board Support
The Board shall be supported by officers as required, and in any event the BCP Lead Officer for the CCG and the BCF Project Manager.

Role of the Partnership Board
The Partnership Board shall

- Provide strategic direction on the Individual Schemes
- Receive financial and activity information
- Review the operation of this Agreement and performance manage the individual schemes
- Agree such variations to the s75 Agreement from time to time as its thinks fit
- Review and agree annually revised Schedules as necessary
- Request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Pooled Fund
- Manage the performance of the Better Care Fund in line with the key performance indicators agreed nationally
- Review and agree annually a risk assessment and a Performance Payment protocol
- Receive and approve business cases for proposals against the pooled budget

Meetings
The Partnership Board will meet at least quarterly at a time to be agreed, following receipt of each quarterly combined report of the Pooled Fund Managers. The Partnership Board may, at its discretion, meet more frequently as agreed between the partners.

The quorum for meetings of the Partnership Board shall be a minimum of two representatives from each of the Partner organisations

Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

Where a Partner is not present and has not given prior written notification of the intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

Minutes of all decisions shall be kept and copied to the Accountable Officer/ Proper Officer within ten working days of every meeting.

Annex 1: Pooled budget Partnership Board Terms of Reference

Delegated Authority
The Partnership Board is authorised within the limits of delegated authority for its members (which is received through their respective organisations own financial scheme of delegation) to

- Authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund and
- Authorise a Lead Commissioner to enter into any contract for services necessary for the provision of services under an Individual Scheme

The Partnership Board shall provide updates on its work to the Darlington Health & Wellbeing Board.

Members of the Partnership Board shall report on the work of the Board through their host organisations governance structures.

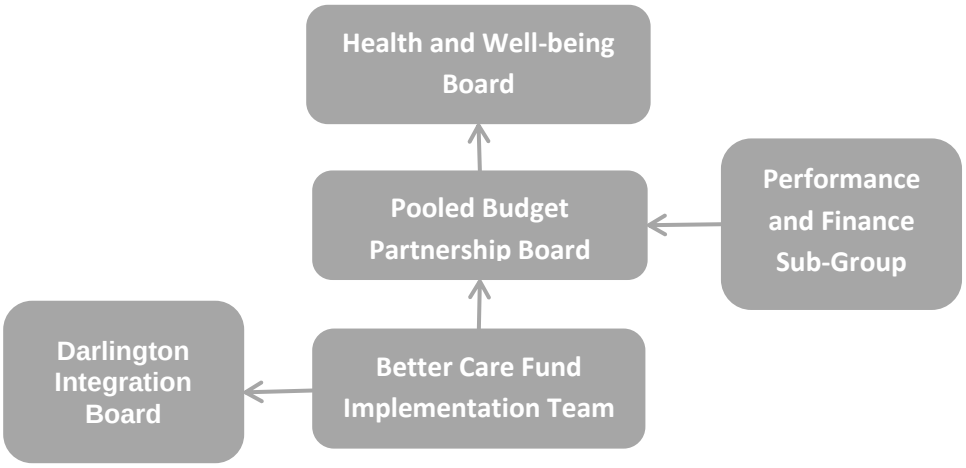
Information and Reports
Each Pooled Manager shall supply to the Partnership Board on a quarterly basis the financial and activity information required under the Agreement. The Partnership Board may, at its discretion, request a more frequent provision of information, as agreed between the partners.

Post – Termination
The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their representative contributions at that time.

Pooled Fund Management
Each pooled fund shall have a designated Pooled Fund Manager who will be an existing officer within one of the Partners, with the following duties and responsibilities:-

(a) The day to day operation and management of the Pooled Fund;
(b) Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme specification;
(c) Maintaining an overview of all joint financial issues affecting the Council and the CCG in relation to the services and the Pooled Fund;
(d) Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;
(e) Reporting to the Partnership Board as required;
(f) Ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with the s75 Agreement;
(g) Preparing and submitting to the Partnership Board quarterly reports (or more frequent reports if required) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required to monitor the effectiveness of the BCF and to enable the CCG and the Council to complete their own financial accounts and returns;
(h) Preparing and submitting reports to the Health and Wellbeing Board as required by it.

Annex 1: Pooled budget Partnership Board Terms of Reference



The Partnership Board may agree to the virement of funds between Pooled Funds, in accordance with Council and NHS Financial Regulations.

Supplementary Information

- Meetings will be held at the CCG offices in Darlington and Town Hall Darlington on an alternate basis
- These Terms of Reference to be reviewed annually and any change recorded as a decision in the minutes of the Board

Performance and Finance Sub-Group

Purpose of the meeting: To develop the performance report and budget report for the Pooled Budget Partnership Board.

Document history

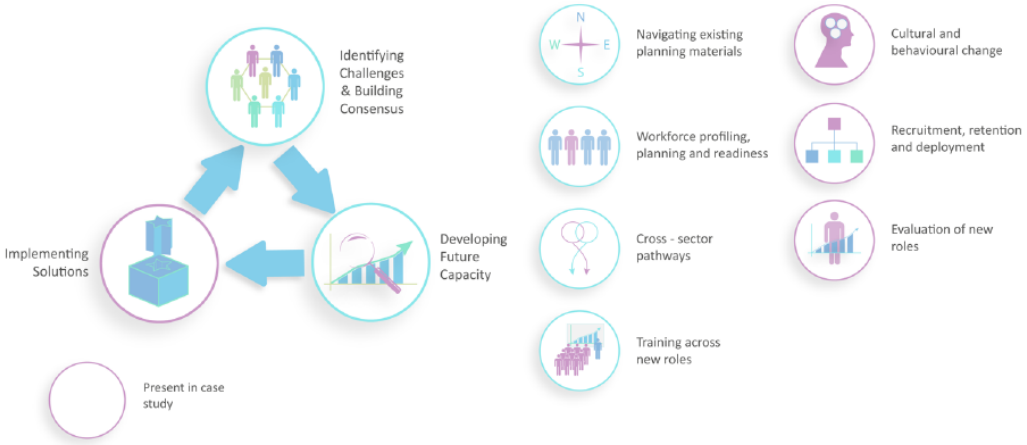
Version	Date	Status	Summary of changes
1	11/08/16	DRAFT	
2	Nov 16	ADOPTED	Reference added to alternating chairing and location
3	31/03/17	REVIEW	Changes highlighted in the review document. Changes align the ToR more closely with others in the region and to include a review schedule

Date of next scheduled review: March 2018

ANNEX 2: Community Matrons Case Study

The Better Care Fund

DARLINGTON: COMMUNITY MATRONS IN CARE HOME INITIATIVE



Key Features:

Improved patient health outcomes and experiences, staff satisfaction and reduction of unscheduled secondary care utilisation enabled through:

- Multi-stakeholder workshops to identify key challenges in the community and identify common issues between sub-population groups; and the
- Design of a solution-based initiative that capitalised on clinical expertise of community matrons and support of assistant practitioners to build capabilities and improve communication and decision making of care home staff.

Background

In 2014, a partnership between the Darlington Clinical Commissioning Group (CCG) and Darlington Borough Council received £3.9m through The Better Care Fund (BCF) to transform care for the frail elderly in the borough.

At the outset of the project, the partnership targeted two sub-populations: the frail elderly and those with long-term conditions (LTCs). As a result of stakeholder workshops in April 2014, the partnership determined that the two groups had similar needs and, therefore, could be addressed by a combined initiative. The workshops identified unplanned admissions from care homes as a key area of focus due to negative impact on patient clinical quality and quality of life and potentially avoidable financial costs.

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ANNEX 2: Community Matrons Case Study

The Better Care Fund

Solution

The co-design process identified emergency and ambulatory admissions and discharging inpatients from hospital in a timely manner as primary challenges for the frail elderly and those with LTCs. To address this, Darlington designed and implemented two distinct initiatives: *community matrons in care homes* and *GPs in wards*. The remainder of this case study focuses on the community matrons in care homes initiative.

Multidisciplinary Team (MDT)

An MDT supported both initiatives by creating a single entity to coordinate communication and access to health and social care support for the elderly and those with LTCs. This served as a resource for both matrons and GPs to access by referring issues for discussion and shared knowledge.

Under this initiative, community matrons and assistant practitioners were redeployed to deliver preventive and reactive care to patients in care homes with the aim of reducing avoidable emergency admissions and A&E visits.[1]

Darlington launched this initiative in March 2014 with four community matrons in 10 care homes and expanded the programme a year later to eight community matrons and four assistant practitioners in 20 care homes. The initial 10 care homes were targeted based on their high rates of emergency admissions and A&E visits.

The matrons and assistant practitioners performed both proactive and reactive work.

- In the **proactive** role, matrons acted as residents' "key workers", which included developing emergency health care plans to permit residents' care to be managed in the care home rather than with emergency hospital admissions, based on the residents' personal preferences. Assistant practitioners also provided proactive support by supporting patients with their care plan and educating care home staff on hygiene, hydration and nutrition.
- In the **reactive** role, available seven days a week, care homes could contact community matrons rather than calling ambulances or sending patients to A&E in the event of an emergency.

Findings

Between April 2014 and December 2015, Darlington observed a 46% reduction in emergency admissions and a 36% reduction in A&E attendances from care homes. This equated to approximately 60 fewer emergency admissions per month and approximately 70 fewer A&E visits per month. To illustrate the value of secondary care savings, and using an average cost of £1,748 for an unplanned inpatient admission and £132 for an A&E visit, the reduction in use of secondary care equates to savings of approximately £114,000 monthly or £1.4 million annually.[2] These are gross savings estimates that do not reflect the cost of the intervention. However, a

[1] See https://www.healthcareers.nhs.uk/explore-roles/clinical-support-staff/assistant-practitioner for more information on the assistant practitioner role.

[2] Rounded to the nearest thousand. Source: Reference Cost 2014-2015 (Department of Health) for A&E and PSSRU 2015 for Emergency Admission. Emergency Admission cost reflects the unweighted average of short (£608) and long (£2,888) non-elective inpatient stays.

submission to Health Service Journal (HSJ) indicates that Darlington invested £980,000 in this programme, making it cost-effective within the first year.

In addition, anecdotal evidence suggested qualitative benefits, including increased patient and GP confidence in matrons, better understanding for carers of conditions that can be treated in care homes and changes in clinical policies and procedures within care homes for issues including falls, infections and emergency contacts. Stakeholders considered these to be significant achievements as they improved patient experience, care quality, and effective service utilisation.

Critical Enablers

- **Highly targeted intervention:** Community matrons and assistant practitioners were assigned to specific care homes (based on high prevalence of avoidable admissions) and focused their efforts on reducing avoidable admissions and A&E visits through proactive and reactive interventions.
- **Building capabilities**: Care home staff were supported to develop the knowledge, skills and overall confidence to respond to simple health needs of residents in the home.
- **Appropriate staff deployment:** Assistant practitioners built relationships with care home staff and managed routine patient needs, which allowed community matrons to harness their experience and clinical expertise with more complex patients. Both roles enabled more efficient use of primary care resources.
- **Targeted training and clinical supervision:** Community matrons underwent prescribing training and ongoing health and social care training (e.g. minor injuries course) with clinical supervision provided by GPs.

Key Considerations

Several local health economies have adopted similar initiatives to Darlington's community matrons in care homes with success.[3] For example, starting in 2008, community matrons in East Surrey visited care homes to reduce avoidable hospital admissions. Their role included providing support and advice to care home staff, monitoring and reviewing emergency ambulance calls from care homes and promoting the use of advanced care planning. In addition, the community matrons set up and coordinated quarterly nursing home forum meetings, so that nursing home staff could meet key professionals from the multidisciplinary team and acute hospital, with the aim of working together to reduce hospital admissions. At the six-

[3] This includes Ashford CCG, Canterbury and Coastal CCG, North West Surrey CCG, West Sussex CCG, Surrey Heath CCG, and many more.

month audit, 41 hospital admissions had been avoided and a reduction of 9.1% in calls to the ambulance service had been observed.[4]

Research suggests that a large number of emergency admissions and A&E attendances for older people come from care homes. In addition, there is variation in the care home use of these services with some care homes responsible for significantly more utilisation of emergency services than others.[5] Given the successes in Darlington and other similar initiatives, future efforts to reduce unnecessary emergency utilisation from care homes by deploying community matrons to targeted locations could have substantial positive impacts on patient care quality.

Challenges

- **Patients and carers were reluctant to engage** with community matrons and assistant practitioners, as they wanted to be seen by a GP. Participants addressed this by building trusted relationships and demonstrating the benefits of the new ways of working.
- **Initially reactive work dominated community matron time** as some care homes utilised matrons heavily, including for "see and treat" work that would typically fall to GPs. However, once the initiative was well established, the burden decreased as care homes were better able to manage risk. Furthermore, the community matrons were pleased to have developed their clinical skills to undertake this role and were able to do so with greater confidence.
- **High staff turnover in some care homes** meant relationships and trust between matrons and care home staff often needed to be rebuilt and staff continuously re-educated. Matrons and assistant practitioners worked with the care home managers to embed policies to mitigate against this issue.

References

Interviews were conducted with representatives from Darlington CCG, local GPs, community matrons, assistant practitioners and Care UK.

Documents reviewed include:

- Submission to HSJ
- Care home costs – anonymised data
- MDT Design Document for Frail Elderly/LTC in Darlington

This case study was prepared by Optimity Advisors, a leading multi-industry strategy, operations, and information technology advisory firm with multiple locations

[4] http://www.nursingtimes.net/roles/older-people-nurses/reducing-hospital-admissions-from-care-homes/5053471.fullarticle

[5] See for example, "Focus on: Hospital Admissions from Care Homes." Quality Watch (2015). http://www.health.org.uk/sites/default/files/QualityWatch_FocusOnHospitalAdmissionsFromCareHomes.pdf

ANNEX 3: iBCF first quarterly monitoring report

QUARTERLY REPORTING FROM LOCAL AUTHORITIES TO DCLG IN RELATION TO THE IMPROVED BETTER CARE FUND					
A1. Provide a scene-setting narrative for Quarter 1 in relation to the additional funding for adult social care announced at Spring Budget 2017.					
Darlington UA is currently the 5th best Local Authority for DToC nationally and the aspiration is to maintain this performance. It has maintained relatively high levels of spend per head of population on ASC compared to similar Local Authorities. This level of expenditure is not sustainable in the long term and a transformational shift has to take place in order to manage demand, maximise independence, deliver personalised outcomes and promote a cost effective and stable market. This approach will benefit the health and social care system as a whole. It will continue to reduce pressure on the local NHS system and support effective and efficient patient flows. It will meet condition 4 of the BCF, in that, it will be spent on social care needs, relieve pressure on the NHS and ensure a continued focus on hospital discharge.					
A2. Explain how has this additional money has affected decisions on budget savings that may otherwise have been required.					
The intention is to allocate 50% to offset expenditure on current pressures and demands and 50% to support transformational activity to enable system changes to take place. The intention is to achieve a model of care and support that can manage demand, in a sustainable way, by year three, beyond which there is no guarantee of any additional funding. The rationale for this approach is that Darlington Borough Council is currently July 2017) the fifth best performer nationally in respect of delays to social care related transfer of care. The Council is also a high spending authority by comparator group in terms of per-head of population expenditure on social care. These two circumstances are linked, and investing in the ongoing delivery of the core Adult Social Care offer, while transformational changes take place, will benefit the health and social care system as a whole. The new grant funding will be used to offset expenditure on current pressures and demand. This will reduce the immediate ASC budget pressure and achieve a more financially stable position for ASC in the medium term.					
A3: What are the main initiatives/projects that this money will be used to support? You do not need to complete every column in the table below, but please name as many initiatives/projects as you consider relevant. You can provide further information to the right of the table if you want to describe more than 5 projects.					
	Initiative/Project 1	**Initiative/Project 2**	**Initiative/Project 3**	**Initiative/Project 4**	**Initiative/Project 5**	**Initiative/Project 6**

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A3a. Please provide an individual name for each initiative/project (this is so that they can be identified in later quarterly returns).	Investing in the ASC care offer	Reablement	NMC - an agile workforce	Telehealth and assistive technology	Online services and directory	Seven Day Services
A3b. Please briefly describe (in general no more than 2 to 3 lines) the objectives/expected outcomes for each initiative/project. You will be expected to comment on progress in later quarters.	Embedding strength-based assessment/support planning, by increasing capacity will improve an individual's independence, ability to self-care and reduce the potential for future service need. Locating grant funding in key, core areas will provide more stability for ASC and the system as a whole. It will create the conditions needed to continue to develop and embed the transformational changes that will	Investment to improve the reablement pathway will contribute to reducing NEA and maintenance of good DToC performance. The expansion of reablement provision will introduce more 'step up' capability'. It will also strengthen the social care contribution to partnership working in the areas of hospital discharge and Teams Around Practices.	The New Models of Care currently being proposed the CCG present the opportunity to align staff around real or virtual hubs. A mobile and agile workforce is needed to enable ASC to work efficiently and flexibly with partners. Investment in agile technology will support social care staff to maximise their capacity and contact time in the community, and will facilitate working from different	To invest in telecare equipment, and its deployment, particularly in respect of falls prevention. A fall is often a trigger event for reduced independence and often results in unnecessary permanent care home admissions. Grant funding will enable the use of assistive technology to become a default offer that will maximise self-care and independence.	The implementation of online systems to provide people with tailored information, advice and guidance and effective sign posting to community and voluntary sector services.	Develop service capability across the week in specific areas of the social care pathway. This will improve the availability of the social care skill set within RIACT and the interface with health partners. This will support discharge to assess initiatives and the implementation of trusted assessor approaches.

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	move the system towards achieving a sustainable model of care and support.		locations. This will support effective multi-disciplinary working and the delivery of integrated care around the person.			
A4a. Have you engaged with your care providers in light of the new funding? Please choose yes or no from the drop-down menu.					Yes	
A4b. If you have answered 'Yes' to question A4a, please describe what action you have taken. If you have answered 'No' to question A4a, you should outline your plans for engaging with your care providers. .						
Proposals discussed at Pooled Budget Partnership Board, and further detail being worked up with commissioning leads from CCD and Darlington UA for presentation to HWB						
				2016/17	**2017/18**	
A5a. Please provide your average unit costs for home care for 2016/17, and on the same basis, the level that you are setting for 2017/18. (£ per contact hour)				13.22 standard and 13.44 enhanced	13.53 standard and 14.09 enhanced	
A5b. Please provide your average unit costs for care home provision for clients aged 65+ for 2016/17, and on the same basis, the level that you are setting for 2017/18. (£ per client per week, excluding full cost payers, 3rd party top ups and NHS-funded nursing care)				455.55 is the average across our range of residential fee levels	466.08 is the average across our range of residential fee levels	
Section B						
B1. In comparison with plans made before this additional funding was announced, what impact do you anticipate on the:						
	Number of home care packages provided in 2017/18:	**Hours of home care provided in 2017/18:**	**Number of care home placements in 2017/18:**			

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B1A. Please provide figures to illustrate the impact.	Our transformation programme aims to prevent need and maximise independence with metrics in place to monitor impact.	Our transformation programme aims to prevent need and maximise independence with metrics in place to monitor impact.	Our placements have reduced on target over the past two years and we plan to maintain this focus, reporting progress through BCF and the Health and Wellbeing board.		
Section C					
C1. Please provide any further information you wish us to be aware of, and use whatever further specific metrics you consider appropriate for your area; for example this might include reablement, timeliness of assessments, carers, staff capacity etc. You will be expected to update these each quarter.					
We expect an increase in the population aged 70-74 of around 20% (just under 5000 to almost 6000) by 2021 on 2016 figures. This will be followed by an increase of 30% - 40% in the 75 - 80 cohort, which will grow from just over 4000 to almost 5500 between 2020 and 2025. These forecasts will influence the design of services. Delivery will be reported through Health and Wellbeing Board in line with the BCF requirements, with the mandated metrics for DToC, admissions to residential care, reablement effectiveness and non-elective admissions.					
Section D					
D1. The grant determination requires you to work with the relevant CCG(s) and providers to meet National Condition 4 (NC4) of the Integration and Better Care Fund. NC4 states that all areas should implement the High Impact Change Model for managing transfers of care to support system-wide improvements in transfers of care. Please set out, from the local authority's perspective, what progress is being made to implement the High Impact Change Model with health partners and the intended impact on the performance metrics, including Delayed Transfers of Care.					

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The Local Authority and health partners have been working together on discharge planning and delivery for a number of years and are probably at the "mature" stage in terms of change 3 (Multi-disciplinary discharge teams) and Change 8, enhancing health in care homes (ref BCF Exchange Case Study on Darlington's community matrons). Social Care staff participate in twice daily on-ward huddles and have an escalation process in place to facilitate discharge where necessary. We have very well established relationships with patient flow teams at the hospital, robust communications, and social care staff participate in the weekly regional OPEL teleconferences. The hospital has in place "your ticket home" to ensure discharge is discussed as soon as possible after admission.
A rapid response service implemented over winter proved very effective and allowed discharge to assess to function well, along with seven day working. The use of trusted assessors is constrained currently by existing systems but social care teams accept health assessments.

We will jointly be carrying out a self-assessment against all eight changes and developing a plan, with the intention of maintaining our current good DToC performance, delivering the targets set out in the DToC metric and preserving our existing good relationships. A specific discharge group for Darlington is in place to further progress the work.

Annex 4: guide to where KLOEs are addressed

This table provides an approximate location of where KLOEs are specifically referenced in the plan, although these specific references are not the entire evidence for the KLOEs; the whole plan makes up the evidence to satisfy the KLOEs.

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
National condition 1: jointly agreed plan (Policy Framework)	1. Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and wellbeing board? 2. In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?	1. Are all parties (Local Authority and CCGs) and the HWB signed up to the plan? 2. Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan? 3. Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach?	Planning Template: introduction/foreword page 4 and page 37 Narrative plan pages:
National condition 2: Social Care Maintenance (Policy Framework)	3. Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19 **1.79% for 2017/18 and a further 1.90% for 2018/19*	4. Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template? 5. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution? 6. In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole? 7. Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision	Planning Template Narrative plan page 38

Annex 4: guide to where KLOEs are addressed

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
National condition 3: NHS commissioned Out of Hospital Services (Policy Framework)	4. Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?	8. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? 9. If an additional target has been set for Non Elective Admissions; have the partners set out a clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid? 10. If a contingency fund is established is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?	Planning Template Narrative plan page 39 Page 46 Page 46
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	5. Is there a plan for implementing the high impact change model for managing transfers of care?	11. Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken; including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? 12. Is there evidence that a joint plan for delivering and funding these actions has been agreed? 13. If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information?	Planning Template Narrative plan Page 39 Page 39

Annex 4: guide to where KLOEs are addressed

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
Local vision for health and social care	6. A clear articulation of the local vision for integration of health and social care services?	14. Does the narrative plan articulate the local vision for integrating health and social care services, including changes to patient and service user experience and outcomes, and a strategic approach to housing, social care and health, cross-referenced and aligned to other plans impacting on integration of health and social care such as STPs or devolution deals? 15. Is there an articulation of the contribution to the commitment to integrate health and social care services by 2020 in line with the intent set out in the 2015 spending review and the BCF policy Framework? 16. Is there a description of how progress will continue to be made against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework?	Narrative plan page 5 Other local plans that contribute to integration (e.g. STP) Joint strategic needs assessment (links on page 9) The vision in context: Page 6
Plan of action to contribute to delivering the vision for social and health integration	7. Does the BCF plan provide an evidence-based plan of action that delivers against the local needs identified and the vision for integrating health and social care?	17. Is there a robust action plan that addresses the challenges of delivering the vision, including: • Quantified understanding of the current issues that the BCF plan aims to resolve • Evidence based assessment of the proposed impact on the local vision for integrating health and social care services through the planned schemes and joint working arrangements	Narrative plan page 25

Annex 4: guide to where KLOEs are addressed

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
Approach to programme delivery and control	8. Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when needed?	18. A description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF plan? 19. A description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? 20. Does the narrative plan have a clear approach for the management and control of the schemes? including as a minimum: • Benefit realisation (how will outcomes be measured and attributed?) • Capturing and sharing learning regionally and nationally • An approach to identifying and addressing underperforming schemes	Narrative plan Local vision, page 5 Page 45
Management of risk (financial and delivery)	9. Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?	21. Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description of how these risks will be proportionally mitigated or managed operationally? 22. If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care or IBCF grant at risk? 23. Is there sufficient mitigation of any financial risks created by the plan if a risk share has not been included?	Narrative plan pp34 - 36 Market Position Statement Organisational risk logs

Annex 4: guide to where KLOEs are addressed

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
Funding contributions: Care Act, Carers' breaks, Reablement DFG iBCF	10. Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose and this is appropriately agreed with the relevant stakeholders and in line with the National Conditions?	24. For each of the funding contributions, does the BCF evidence: • That the minimum contributions set out in the requirements have been included? • How the funding will be used for the purposes as set out in the guidance? • That all relevant stakeholders support the allocation of funding? • The funding contributions are the mandated local contributions for: • Implementation of Care Act duties • Funding dedicated to carer-specific support • Funding for Reablement • Disabled Facilities Grant? 25. Does the planning template confirm how the minimum contribution to Adult Social Care and the funding for NHS Commissioned Out of Hospital Services will be spent? 26. Does the BCF plan set out what proportion of each funding stream is made available to social care and that the improved Better Care Fund has not been offset against the contribution from the CCG minimum? 27. Is there agreement on plans for use of IBCF money that meets some or all of the purposes set out in the grant determination?	Planning Template Narrative plan page 43 Page 41 Page 41 Page 41
Metrics – Non Elective Admissions	11. Has a metric been set for reducing Non Elective Admissions?	28. Does the narrative plan include an explanation for how this metric has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? 29. Has a further reduction in Non Elective Admissions, additional to those in the CCG operating plan, been considered?	Planning Template Narrative plan page 48

Annex 4: guide to where KLOEs are addressed

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
Metrics – Non Elective Admissions (additional)	12. If a metric has been set for a further reduction in Non Elective Admissions, beyond the CCG operating plan target, has a financial contingency been considered?	30. Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target? See also National Condition 3.	Narrative plan Planning Template
Metrics Admissions to residential care homes	13. Has a metric been set to reduce permanent admissions to residential care?	31. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?	Planning Template page 47
Metrics – Effectiveness of Reablement	14. Has a metric been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?	32. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of the reablement funding allocation for health and social care and other BCF schemes on performance in 2017-19?	Planning Template page 48
Metrics Delayed Transfers of Care	15. Have the metrics been set for Delayed Transfers of Care?	33. Have all partners agreed a metric for planned reductions in delayed transfers of care across the HWB that is at least as ambitious as the overall HWB target for reductions of DToC by November 2017? 34. Is the metric in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area set out in the DTOC template? 35. If the local area has agreed changes in attribution from those set out in the template is there a clear evidence base and rationale for those changes? 36. Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan?	Planning Template Narrative plan page 49 Related schemes and models impacting DTOC beyond BCF A&E improvement plans

Annex 4: guide to where KLOEs are addressed

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
		37. Have NHS and social care providers been involved in developing this narrative?	
Integrity and completeness of BCF planning documents	16. Has all the information requested in the DTOC and planning templates been provided and are all the minimum sections required in the narrative plan elaborated?	38. Have the DTOC template, planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? (Better Care Support Team will carry out central data validation)	DTOC template Planning Template Narrative plan